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SAN FRANCISCO MENTAL HEALTH BOARD

Mayor Edwin Lee

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, January 9, 2013
City Hall
One Carlton B. Goodlett Place
2nd Floor, Room 278
6:30 – 8:30 PM

CALL TO ORDER

ROLL CALL

AGENDA CHANGES

Item 1.0 DIRECTORS REPORT

For discussion.

GOVERNMENT
DOCUMENTS DEPT

JAN - 4 2013

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1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public Comment

Item 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

For discussion.

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Updates

2.2 Public Comment

Item 3.0 PRESENTATION: OVERVIEW OF SERVICES AVAILABLE AND SYSTEM RESPONSE TO ADULTS AND JUVENILES IN CRISIS IN SAN FRANCISCO: KARA CHIEN, MENTAL HEALTH BOARD MEMBER AND SF PUBLIC DEFENDER AND SGT. KELLY DUNN, MENTAL HEALTH BOARD MEMBER AND SF POLICE SERGEANT.

For discussion

3.1 Presentation: Overview of Services Available and System Response to Adults and Juveniles in Crisis in San Francisco: Kara Chien, Mental Health Board Member and SF Public Defender and Sgt. Kelly Dunn, Mental Health Board Member and SF Police Sergeant.

3.2 Public comment

Item 4.0 ACTION ITEMS

For discussion and action.

4.1 Public comment

4.2 . PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of November 14, 2012 be approved as submitted.

4.3 PROPOSED RESOLUTION: Be it resolved that the notes for the Mental Health Board Retreat on December 1, 2012 be approved as submitted.

Item 5.0 REPORTS

For discussion and possible action.

5.1 Report from the Executive Director of the Mental Health Board.
Discussion regarding upcoming events, conferences, or activities that may be of interest to board members; Mental Health Board budget issues and update on staff work on board projects.

5.2 Report of the Chair of the Board and the Executive Committee.
Discussion regarding Chair's meetings with Community Behavioral Health Services staff, meetings with members of the Board of Supervisors and community meetings about mental health or substance abuse.

5.3 Report from Nominating Committee, Chair: Wendy James
Nominating Committee will announce the slate of officers nominated for 2013, to be voted on at the February 2013 meeting. Additional nominations can be made from the floor as well.

5.4 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

5.5 Report by members of the Board on their activities on behalf of the Board.

5.6 New business - Suggestions for future agenda items to be referred to the Executive Committee.

5.7 Public comment.

Item 6.0 PUBLIC COMMENT

ADJOURNMENT

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3. Special Hearings are usually held at the Department of Public Health, 101 Grove Street, 3rd Floor, Room 300. The same public transportation options as above apply. It is wheelchair accessible.

4. For Special Hearings at other locations, please call for directions or bus information. All locations will be accessible.

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City Hall, Room 244
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San Francisco, CA 94102-4689
Telephone: (415)554-7724
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Edwin Lee
Mayor

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Unadopted Minutes
Mental Health Board
Wednesday, January 9, 2013
City Hall, Room 278
San Francisco, CA

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BOARD MEMBERS PRESENT: M. Lara Siazon Argüelles, Chair; Ellis Joseph, MBA, Vice Chair; David Elliott Lewis, Ph D, Secretary; Kara Chien, JD; Alyssa Landy, MA; Virginia S. Lewis, LCSW, MA; Lena Miller, MSW; Terence Patterson, EdD, ABPP; Alphonse Vinh, MS; Errol Wishom.

BOARD MEMBERS ON LEAVE: Sgt. Kelly Dunn; and Wendy James.

BOARD MEMBERS ABSENT: Lynn Fuller, JD.

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jo Robinson, Director of Community Behavioral Health Services (CBHS); Cecile O'Connor, RN, Executive Director of Dore Urgent Care; Erin Durrah; Idell Wilson; Matthew Green, Conard House, Shelter Monitoring Committee; Ralph Fein, MD; Terezic Bohrer; and three members of the public.

CALL TO ORDER

Ms. Argüelles called the meeting of the Mental Health Board to order at 6:40 PM and welcomed everyone to the new year.

ROLL CALL

Ms. Brooke called the roll.

AGENDA CHANGES

Sgt. Kelly Dunn was unable to be at the meeting to speak so, Cecile O'Connor, Executive Director of Dore Urgent Care and Jo Robinson, Director of Community Behavioral Health Services covered the topics that Sgt. Dunn was going to cover.

ITEM 1.0 DIRECTOR'S REPORT

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

Ms. Robinson began her report with a follow up to the discussion about the Wellness and Recovery Model that the board discussed at the December 1, 2012 working retreat. She shared the 35 page report called STUDENT SUCCESS PROGRAM – Progress Report: the First Two Years, August 31, 2010 to June 30, 2012 and the Multi-Site Holistic Wellness Program Evaluation Summary Report November 2012.

Also the Tree of Hope visual was mentioned at the December 2012 board retreat. She explained that the five-foot Tree of Hope, was an innovative simple visual project started at the OMI Family Center (Ocean Mission and Ingleside). The essence of the project was strengthening wellness and recovery through collaborative efforts among all clinics, clients, family members, caregivers, friends and staff. The Tree of Hope is laden with both inspiring and heart-felt messages as leaves, and these leaves are symbols of nurturing and strengthening of communities. The tree is now on full display in the OMI clinic's reception area.

Please see the attached January 2013 Director's report.

Monthly Director's Report
January 2013

1. San Francisco State University Releases Two Year Outcome Report on Student Success Program

The College of Health and Human Services at San Francisco State University has received funding through both the Mental Health Services Act (MHSA) and the University to support students who are preparing for careers in public health. Called the Student Success Program, they employ a wrap-around and multidisciplinary approach, assisting students in building a healthy and stable lifestyle while in school. Their services are student driven, focusing on the students' short and long-term goals, individual and environmental strengths and assets, potential challenges to academic success, and the types of supports that they believe would be helpful in navigating the university system. The attached report covers progress from the first two years of the program. (See attachment 1)

2. Outpatient Services Documentation Standards and Practices

The documentation manual is now posted. This manual will be posted at the following web site: <http://www.sfdph.org/> As with any manual, updates will need to be made as policies and regulations change. When updates are distributed, please be sure to replace old sections with updated sections.

3. SFSU Student Success Program: 2-year Progress Report

The Student Success Program (SSP) supports students who are preparing for careers in the behavioral health and the human services, by assisting them in building healthy and stable lifestyles while in school. The goals of the SSP are to increase access, enhance retention and maximize graduation rates among students and family members with lived behavioral health experience. SSP

services are student-driven and include counseling, coaching, advising, crisis intervention, career planning and professional development, peer mentorship, community building and social activities.

Findings revealed over the past 2 years

- Students reporting behavioral health issues are significantly more likely to enumerate a multiplicity of needs & goals related to physical & mental health, academic performance, relationships, as well as financial & material stability
- In the course of students' ongoing relationship with the SSP, they become more interested in serving the community as providers or advocates
- Most frequently presenting issues: challenges related to physical and mental health, getting back on track academically after setbacks related to life stressors, loneliness and isolation
- Services are most effective when implemented in an open-ended fashion over an extended period of time
- Drop-in services are effective, with 1,124 contacts between August 22, 2011 and May 19, 2012

Highlights

- During its first two years of operation, the SSP has served (130) students through intakes and individual services
- 21 students who were served by the Student Success Program (SSP) during its first two years of operation have graduated
- Of those 21 students who graduated, 71% were either employed or were volunteering in a position related to mental health; and 15 identified as consumers or family members
- SFSU was awarded an MHSA Student Mental Health Initiative grant (\$410,000) to provide campus-wide prevention and early intervention programming – including curriculum development and training, peer-to-peer support and suicide prevention – which will substantially increase the reach of the Student Success Program

4. County, State and Federal Initiatives – Child, Youth and Families System of Care

A number of county, state and federal initiatives will define CYF work plan for 2013. Some of these have clear directions, others need more organization but they all involve building strong collaborative relationships internally and externally. These initiatives are:

- Continued integration of Behavioral Health and Primary Care in San Francisco;
- Federal health care reform;
- Improve Substance Use Disorder treatment in CYF;
- Make our EHR user friendly and efficient;
- Integration of Healthy Families into MediCal;
- Implementation of Katie A. statewide (entitlement of at risk or dependent foster care youth to mental health services);
- Continued rollout of Educationally Related Mental Health Services (ERMHS formerly 3632);
- Trauma informed care;

- Indications that EPSDT will become outcome based statewide; and
- Realignment of behavioral health funds to the county from the state.

CBHS Child, Youth and Families System of Care will be working with CBHS leadership, staff and stakeholders to form work plans that will successfully implement these initiatives.

5. Providers 2012

To: All San Francisco Children Youth and Families Providers

From: Ken Epstein

I want to take a moment to say thank you for all the service you provide to the children, youth and families of San Francisco. I know the work we collectively do each day is constantly challenged by internal and external barriers. Yet each day, each one of your agencies and programs, seeks to change something in the lives of the children, youth and families you touch. For this we are grateful.

I have now been Director of Children Youth and Families for over 5 months. My welcoming has been very warm and my learning curve very steep. While I have been involved in the San Francisco system of care for over 25 years, I am humbled by the complexity and challenges inherent in building, sustaining and improving the services we provide. At the same time I feel fortunate to work in such a diverse and vibrant environment of ideas, programs and clinical practices.

In the coming year it is my goal to begin to establish a process of leadership that incorporates all the strengths of the San Francisco community, addresses honestly the barriers and constraints and work towards shaping the entire system to be a model for California and the nation. There is simply no reason why San Francisco should not be the center point for innovation and practice excellence.

Specifically, below are some of the initiatives and processes I intend to oversee as we move towards a shared vision of excellence, participation and success in our provision of behavioral health services to those most in need.

- **Trauma Informed Initiative:** Many of you have participated in the initial meetings to discuss our plan to become a trauma informed system throughout the life cycle. This means that all of our work will be influenced by a foundational understanding of trauma from birth to death, and all service providers from clerk to psychiatrist will have a shared terminology and knowledge about trauma. We are currently finishing the process of vetting the idea with providers, administrators and people with lived experience. In the next five months we will develop a curriculum and a way to deliver the training in a sustainable way. The hope is to begin training by the fall of 2013. In the next six months we will be initiating small acts of change that will infuse the process with excitement and allow us to test out some new ideas.
- **Substance Abuse Treatment for Children, Youth and Families:** Some of you have participated in some conversation about some of the resources and gaps in our current system for treating substance abuse in youth. We have also discussed this issue with our partners at Human Services Agency, Probation and Education. In the coming year we will begin a planning process to look at the gaps and strategize about how to meet the identified needs.

- **Clinical Excellence:** In the coming year we will establish some forums to exchange successes, best practices, innovative models and even failures to learn together how to best build an effective treatment system for the children, youth and families. We are hoping to integrate clinical presentations into the providers meeting quarterly and establish some other forums for sharing best practices.
- **Children, Youth and Family Advisory Group:** I am planning on establishing an advisory group of youth and families with lived experience in a system of care to sort through the ways our system does or does not meet the needs of the folks we serve. I intend to have an organizing meeting in the next 2-4 months and structure the advisory committee around the feedback from the initial focus groups.
- **Providers Meeting:** Provider relations are central to a functional system. Once a month we come together as a system. This meeting has currently been focused on important operational issues. It is equally vital to have a space for us to talk together about the challenges in the system and to strategize about ways to address those challenges programmatically and clinically. I intend to reorganize the providers meeting to meet the ongoing need to address operational needs and develop a place to discuss strategy. *For now I am asking for volunteers to meet with me to discuss how best to do this.* Stay tuned for an announcement for a meeting.
- **Internal organization:** As some of you may know there were three key retirements besides Sai Ling Chan-Sew. We are currently filling these three positions and this will help us operate more efficiently. Currently the managers you interact with daily have been carrying a double load. They have been incredible but we need more support to move the system forward effectively.
- **Integrating county, state and federal initiatives:** Perhaps for those of us that have been in the field for a while we have seen other times with tremendous change in mental health and substance abuse. However, I will argue that the next few years will witness significant change and it will take tremendous effort to not only meet the demands but to exceed them and create a better system of care for our youth and families. Some of the most recent changes involve:
 - Integration of Behavioral Health and Primary Care in San Francisco
 - Federal health care reform
 - The integration of Healthy Families into Medical
 - Implementation of Katie A. statewide (entitlement of at risk or dependent foster care youth to mental health services)
 - The continued rollout of Educationally Related Mental Health Services (ERMHS formerly 3632)
 - Indications that EPSDT will become outcome based statewide
 - Realignment of behavioral health funds to the county from the state
- **Building strong relationships with our county child and youth serving partner agencies:** San Francisco has many multi-agency initiatives and it is this very process that makes our

future so bright. At the same time it is these relationships and the different missions of each agency that can sometimes complicate our collaboration. I will be working on developing a shared vision that allows the agencies to grow collaborative prevention and intervention initiatives and creative funding.

- **Outcomes and performance:** Children's System of Care has been working for over five years on developing a system wide outcomes and performance evaluation system that begin to inform us collectively about how we are doing, individually how each program and service is doing and most importantly are we impacting the lives of the children, youth and families we serve. Outcomes are a complicated subject and my intention is to present the data we have, discuss it in the aggregate with larger groups, specifically with individual programs and incorporate all of that feedback into a system improvement process. If we do this right together we will be able to use data that we have, incorporate data that you have, and discuss data that may be missing to generate a picture of where our system is today and where we need to improve the system.

These are the highlights of the initiatives I am hoping to support this year and beyond. I am sure that as things go there will always be something that filters from youth and families or from providers or from policy makers that will shift the priorities. However, it is my challenge to keep the overall vision in mind, align that with all of behavioral health and within the context of the Public Health agenda and mission. I look forward to all of your participation going forward.

6. HOPE

The O.M.I. Family Center has been participating in a 15 month long statewide learning collaborative sponsored by the California Institute of Mental Health. The O.M.I. Family Center is one of 17 teams throughout California who are working together to learn how to advance Wellness and Recovery Practices into our daily clinical work.

The "Tree of Hope" project was born out of the idea of creating a collaborative project for all clinic clients, family members, caregivers, friends and staff to complete together that would build awareness of the importance of strengths in our lives and in particular in our path to wellness and recovery.



The first image is of our 5 foot felt tree entitled "Growth of Hope" which was located in the clinic waiting room. Each leaf on the tree is a strength which was identified by a client, family member, friend, or staff as being important to them. Each person who came into the waiting room was given the opportunity to choose a leaf and to write a strength that they presently have or one that they wish to develop. This very simple idea generated many heartfelt responses and really demonstrated the importance of hope in all of our lives.

The second image is a digital “Growth of Hope” tree. All of identified in the original were recorded and downloaded software program. The size typeface correlate with the that were identified with that on the original “Growth of tree is a visual snapshot of the within the O.M.I. Family and now greets every visitor clinic.



version of the the strengths version of the tree into a word cloud and boldness of the number of leaves particular strength Hope” tree. This varied strengths Center community upon entering the

7. Holistic Wellness Evaluation Summary

The Office of Quality Management completed an evaluation of MHSA Prevention and Early Intervention’s Holistic Wellness Programs in the fall of 2012. The goals of Holistic Wellness are to engage cultural and linguistic traditions in order to strengthen community resilience to trauma and improve behavioral health outcomes. The three main evaluation questions were the following; 1) How effective are programs in recruiting and engaging their target populations? 2) To what extent have the programs improved community resilience to trauma? 3) How are the programs being implemented? Examples of ongoing Holistic Wellness program activities include YMCA’s Parenting Class, Central City Hospitality House’s Community Arts Program, and Instituto Familiar de la Raza’s embroidery workshop. The programs also organize annual community events such Native American Health Center’s Gathering of Native Americans and YMCA’s Kwanzaa celebration. Overall, the Holistic Wellness Programs are having a positive impact on program participants. They expressed improvement in their physical, mental, and emotional health, as well as social connectedness, community building, and coping skills. Peer leaders, who were trained as part of HW, gained leadership, mentorship, employment development, and community building skills. The program staff were described as being responsive to the needs of their community and helpful in building safe places for the participants. HW program participants offered useful suggestions to improve the programs, such as: improve outreach to isolated community members (i.e., young men, homeless, and older adults), provide child care, make activities more fun, and expand program hours. The agencies plan to organize collaborative programming that will allow them to continue to learn from one another’s innovative culturally and linguistically appropriate activities, explore ways to reach out to each other’s ethnic populations, and cosponsor events in the future. Below are links to a past presentation and summary evaluation report, offering more details on the specific evaluation questions, methods, tools, and findings, or contact Juan Ibarra at 255-3683 or juan.ibarra@sfdph.org (See attachment 2)

8. State Receives Federal Approval, Begins Healthy Families Transition to Medi-Cal

This week, the state officially began the transition of Healthy Families Program enrollees to Medi-Cal. As you may recall, last year's budget trailer bill (AB 1494) required the state to obtain federal approval *prior to* the start of the Healthy Families transition. The federal approvals necessary were amendments to California's existing Section 1115 "Bridge to Reform" waiver, as well as the state's Medicaid Title 19 State Plan. The amendments to the 1115 waiver, effective January 1, 2013, will secure enhanced federal funding for Medi-Cal primary care providers January 1, 2013 to December 31, 2014, and ensure no violations of Medicaid rules pertaining to comparability. The Title 19 State Plan Amendment (SPA) will add the new coverage group (previously the Healthy Families Program) to the Medi-Cal program. Once approved, the effective date of the Title 19 SPA will be September 1, 2013.

The 1115 waiver requirements for "monitoring" the transition are incorporated in the approved, amended "Special Terms and Conditions." According to Department of Health Care Services (DHCS), the monitoring framework will ensure minimal disruption in access to services for children transitioning, and will "provide a process for ongoing data collection, analysis, and a means by which the Department can make adjustments to transition schedules in order to ensure access to and continuity of care. The monitoring will focus on the extent to which the health and dental plans, behavioral/mental health services, and alcohol and substance use services are meeting the needs of the transitioned children and the extent to which eligibility is maintained for these children."

After receiving federal approval of California's existing federal Section 1115 waiver on December 31, 2012, approximately 197,000 children in phase 1-A counties were officially transitioned to Medi-Cal on January 1. Phase 1-A counties (where children are enrolled in a Healthy Families health plan that is also a Medi-Cal managed care health plan in their county) include: Alameda, Riverside, San Bernardino, San Francisco, Santa Clara, Orange, San Mateo, and San Diego. The next group of such children in phase 1-B (approximately 95,000 children) are slated to transition to Medi-Cal on March 1. However, prior to initiating each phase, the state must release an implementation plan that describes health and dental plan network adequacy, continuity of care, eligibility and enrollment requirements, consumer protections, and family notifications.

9. Primary Behavioral Health Care Integration - South of Market Behavioral Health Clinic

The San Francisco Department of Public Health was awarded funding from the Substance Abuse and Mental Health Services Administration (SAMHSA) for Primary Behavioral Health Care Integration (PBHCI) for consumers with serious mental illness (SMI). The grant funding is supporting integration of care and the creation of a health home for clients at South of Market Mental Health Services (SOMMHS). Because the program includes a tremendous amount of technical support and funding for evaluation, we anticipate that this program will serve as a model for DPH in its ongoing efforts to integrate services.

SAMHSA's Goals

The purpose of SAMHSA's program is to support the delivery of coordinated and integrated mental health and primary care services. The goal is to improve the physical health status of

adults with SMI who have, or are at risk for, co-occurring primary care conditions and chronic diseases. Such services support the triple aim of improving the health of those with SMI; enhancing the consumer's experience of care (including quality, access, and reliability); and reducing/controlling the per capita cost of care. The program's goals are:

- Improved access to primary care services;
- Improved prevention, early identification, and intervention to reduce the incidence of serious physical illnesses, including chronic disease;
- Increased availability of integrated, holistic care for physical and behavioral disorders; and
- Better overall health status of clients.

Grant Objectives

1. Serve 550 clients with SMI who were referred by clinicians at SOMMHS (SFFIRST, ISC, FACT, etc)
2. Provide routine screening (BP, HgbA1c) and twice annual primary care visits
3. Provide all clients with RN care coordinator
4. Develop and implement wellness activities
5. Create integrated data systems
6. Facilitate integrated care (case conferences, information sharing, huddles, etc)

Clients seen through PBHCI to date

~35% of SFFIRST clients are enrolled in onsite primary care

~5% of ISC clients are enrolled in onsite primary care

On average, clients have been open at SOMMHS or SFFIRST for more than two years and receiving onsite primary care for more than one year.

Open	With primary care at matched DPH clinics *	With primary care onsite
175 (SFFIRST)	105	65
1072 (SOMMH outpatient)	476	77
*TWHC, HUH, SOM, SEHC, Glide, Potrero Hill, Castro Mission, MNHC		

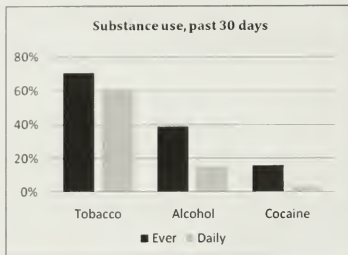
To meet grant goals, more than 10 clients per month need to be referred & enrolled in PBHCI

Since July, about 5 clients per month have been enrolled

Based on our measures, this is what we can know about clients served to date:

- ✓ Most are daily smokers

- ✓ 6% are at significant risk of metabolic syndrome
- ✓ The most common principal diagnosis is schizophrenia (47%)
- ✓ Over 40% were admitted to PMR or EMR in the past 12 mos & many had multiple hospital stays
- ✓ About half show symptoms of trauma & 1 in 5 were depressed most of the past 30 days
- ✓ Most would rate their health as good or better

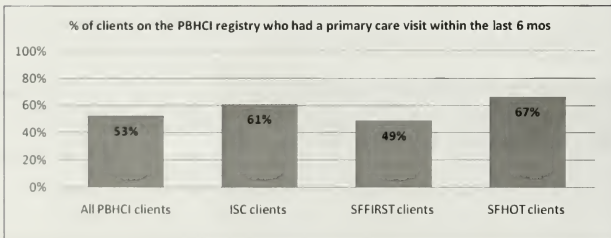


Physical health risks

	N	%
Diabetic	11	6%
Chronic pain	18	10%
HIV	3	2%
High Blood Pressure (>130/85)	27	15%

And about services:

- ✓ 53% of PBHCI clients had blood pressure as part of primary care visit in the past 6 mos
- ✓ 51% of PBHCI clients had HgbA1c drawn as part of primary care visit in past 12 mos
- ✓ 43% of PBHCI clients had fasting labs drawn as part of primary care visit in past 12 mos



10. Men and Women Are Helped Differently by Alcoholics Anonymous

Men and women benefit in different ways from Alcoholics Anonymous (AA), a new study suggests.

Men benefit more from avoiding companions who encourage drinking and social situations in which drinking is common, according to Health24. Women benefit from the program by having increased confidence in their ability to avoid alcohol when they feel sad, anxious or depressed.

"Men and women benefit equally from participation in AA, but some of the ways in which they benefit differ in nature and in magnitude," lead researcher John F. Kelly, PhD, of the Massachusetts General Hospital Center for Addiction Medicine said in a news release. "These differences may reflect differing recovery challenges related to gender-based social roles and the contexts in which drinking is likely to occur." One-third of AA's members are women, the article notes.

The researchers studied more than 1,700 participants in AA, 24 percent of whom were women. They were enrolled in a study called Project MATCH that compared three alcohol addiction treatment approaches. The study tracked participants' success in maintaining sobriety and whether they attended AA meetings. It also evaluated specific measures, such as participants' confidence in their ability to stay sober in certain situations.

In both men and women, AA participation increased confidence in the ability to deal with high-risk drinking situations, and increased the number of social contacts who supported their recovery efforts. For men, the effect of both of those changes on the ability to stay sober was twice as strong, compared with women in the study. Women were much more likely than men to benefit from improved confidence in their ability to stay away from alcohol when they were sad or depressed.

11. Consumer Portal Surveys

Behavioral Health Information Systems is looking forward to implementing the Consumer Portal in mid 2013. We look forward to continuing our partnership with RAMS vocational programs in implementing the Consumer Portal. We have been actively working with the Client Council and RAMS staff to develop a Consumer Portal Survey aimed to assess the computer use among clients. Please be on the lookout for the survey and encourage your clients to complete them. Those of you who attended the Adult Provider meeting were able to pick up paper versions of the survey in the threshold languages. Electronic versions will be sent out this week. For more information, please contact pablo.m.munoz@sfdph.org.

Past issues of the CBHS Monthly Director's Report are available at:

<http://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSdirRpts.asp>

To receive this Monthly Report via e-mail, please e-mail reanna.albert@sfdph.org

1.2 Public Comment

No public comment.

ITEM 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Updates

Ms. Robinson announced that an RFQ was released recently to suggest how to make clinics more welcoming and community friendly. Vocational clients are provided opportunities to learn about painting and laying carpets, and the budget for remodeling some clinics is estimated to be about \$250,000.

Ms. Landy inquired about the Sandy Hook School shooting and the December 24, 2012 shootings in New York and wondered about the preparedness in San Francisco.

Ms. Robinson said that the San Francisco Crisis Team does not normally work after hours but have extended their services in response to the shootings. The Department of Children Youth and Families (DCYF), and Family Youth Services have campus crisis staff who made home visits to people in distress.

She mentioned that CBHS turned press calls over to the Mental Health Association (MHA) of San Francisco, and Eduardo Vega, Executive Director of MHA-SF, recently was on NPR (National Public Radio).

She said that San Francisco County does not take a position on Laura's Law, and its implementation for the county is up to the San Francisco Board of Supervisors.

Mr. Wishom mentioned that 938 Mission St. is a beautiful building.

Ms. Robinson said that, as of 2012, Homeless Connect is available and accessible daily.

2.2 Public comment

No public comment.

ITEM 3.0 PRESENTATION: OVERVIEW OF SERVICES AVAILABLE AND SYSTEM RESPONSE TO ADULTS AND JUVENILES IN CRISIS IN SAN FRANCISCO: KARA CHIEN, MENTAL HEALTH BOARD MEMBER AND SF PUBLIC DEFENDER AND SGT. KELLY DUNN, MENTAL HEALTH BOARD MEMBER AND SF POLICE SARGEANT.

3.1 Presentation: Overview Of Services Available And System Response To Adults And Juveniles In Crisis In San Francisco: Kara Chien, Mental Health Board Member And SF Public Defender And Sgt. Kelly Dunn, Mental Health Board Member And SF Police Sergeant.

Ms. Argüelles introduced the following persons. Kara Chien is a member of the Mental Health Board and a San Francisco deputy public defender who is the Mental Health Unit managing attorney. Cecile O'Connor is the Executive Director of Dore Urgent Care. Jo Robinson, now the Director of Community Behavioral Health Services, was formerly the executive director of Jail

Psychiatric Services. The presenters will provide an overview of crisis response services for adults and juveniles in crisis.

Ms. O'Connor is an RN, and prior to her current position she was with San Francisco General Hospital's Psychiatric Emergency Services (PES). She is now the Executive Director for DUCC (Dore Urgent Care Clinic) which was opened in 2008. Like PES, Dore/DUCC is another triage clinic that does assessment and provides stabilization for clients in an acute border-line escalating psychiatric crisis. Both PES and DUCC/Dore are 24x7 and medically staffed centers. Unlike PES, DUCC is for clients who do not require involuntary treatment, seclusion or restraint. DUCC accepts clients brought in by county behavioral health providers, all law enforcement agencies from SFPD to CHP to Campus Police and Mobile Crisis.

Although PES has seen about 500 people per month, hospitalization has reduced. This reduction is attributed to a greater collaboration in the last five years between PES and Dore where acute border-line escalating crises are triaged quickly to prevent a full-blown debilitating psychosis.

As of January 1, 2013, the EST (Engagement Specialist Team) program targets people known as higher users of multi-service systems because these people have chronic, severe and persistent mental illness coupled with physical problems but they have difficulty staying engaged in treatment and/or services.

Dore works with TAP (Treatment Access Program). San Francisco has more people 5150'd than other counties in the State of California. Progress Foundation has crisis component and ADU (Acute Diversion Unit), one of the 10 programs in Progress Foundation.

Ms. Landy asked what happens if DUCC clients will not stay engaged voluntarily.

Ms. O'Connor stated that PES will step in, if necessary. However, none of Dore clients have ever been referred to PES.

Dr. David Lewis asked for the number of 5150 cases per year.

Ms. O'Connor stated that she does not have the 5150 statistics. She suggested that Sgt. Dunn would be the one with the tracking database.

Dr. David Lewis asked how many nights has Dore turned away people.

Ms. O'Connor stated that the current capacity is four clients per licensed staff.

Ms. Virginia Lewis asked about the outcome statistics on discharged clients.

Ms. O'Connor stated that statistics are electronically maintained.

Ms. Virginia Lewis asked about how many discharged clients return to their homes or go into residential care facilities.

Ms. O'Connor stated that the Avatar system tracks that information.

Ms. Robinson said that ADU might provide the after-discharge statistics.

Ms. O'Connor added that CBHS maintain the statistics to be available for Medicare and MediCal.

Dr. Patterson asked what happens to a person with escalating crisis from a private home.

Ms. O'Connor said that anyone presented to the DORE Urgent Care Clinic is triaged and Mobile Crisis can bring in clients too. SFPD has used SFGH more the DUCC.

Mr. Wishom speaking on behalf of consumer advocates testified that DORE was very good and effective in stabilizing him including providing after care services and follow up support.

Please see the power point presentation prepared by Ms. Kara Chien at the end of the minutes.

Ms. Chien has been a Deputy Public Defender for 23 years. She has been working exclusively in the Mental Health Unit for 12 years. She represents mentally ill clients in both civil and criminal commitment proceedings. She represents patients being held in SFGH for involuntary treatment due to mental disorder. She represents clients in forced medication hearings, also known as Reise hearings. She also represents clients in forensic commitment where her clients are being confined in state hospitals because they were found not guilty by reason of insanity.

She explained that usually when people with mental illness are taken into police or sheriff custody, they often arrived at County Jail No.1 where JPS (Jail Psychiatric Services) can triage them immediately and placed them in County Jail No. 5 located in San Bruno with follow-up psychiatric treatment. The courts may release the mentally ill defendant with a follow-up referral for appropriate services during the pendency of the criminal proceedings. If the person requires medical attention while in custody, then that person is transferred to San Francisco General Hospital (SFGH) Unit 7D for medical treatment. If a person is found to be acutely psychotic while in custody, then that person is transferred to SFGH Unit 7L for psychiatric evaluation and treatment. JPS can assess for clinical appropriateness and recommend clients for the Behavioral Health Court (BHC) as well. Essentially, JPS provides psych housing, treatment and referrals for mentally ill defendant in custody.

In misdemeanor cases, if a mentally ill defendant is found to be incompetent to stand trial, then referrals are made to a locked psychiatric facility for stabilization until the defendant becomes trial competent. Sometimes if they have misdemeanor charges and chronic mental illness, but have strong family support and strong connection with their community providers, then a referral can be made for these clients to live in the community while continuing with psychiatric treatment. In felonious cases, unfortunately in most cases, defendants are sent to the state hospitals for treatment to regain their trial competency.

Juveniles are treated differently. The court may release a juvenile defendant back to home or a residential facility like Edgewood if the minor is found to be incompetent to stand trial. Some mentally ill juvenile may be sent to McCauley (St. Mary's Hospital) for brief involuntary treatment or Metropolitan State Hospital for long-term treatment, although the latter type of hospitalization is very rare. It is more common for juveniles who are 17.5 years old to be transition into adult mental health system. Once they become 18 year old, they will be able to access services provided by CBHS.

For individuals who may have capacity to stand trial with severe mental illness, BHC which was created in 2002 in response to the increasing numbers of mentally ill defendants cycling through the jail and court system. The mission of BHC is to enhance public safety and reduce recidivism of criminal defendants who suffer from serious mental illness by: 1) connecting them with community treatment services; 2) finding the appropriate dispositions to the criminal charges; and 3) requiring regular check-ins with the court. BHC is a collaborative effort of the San Francisco Superior Court, Office of the District Attorney, Office of the Public Defender, Adult Probation Department,

Department of Public Health, Jail Psychiatric Services, Jail Aftercare Services, UCSF Citywide Case Management Forensics and the Sheriff's Department.

Ms. Wishom testified that BHC placed him in community care which helped him in his wellness and recovery, empowered him to enjoy a fuller and more productive life and graduated him from the program. Now, he leverages his lived experiences to be on the board to offer hope to people suffering from mental illness.

Ms. Chien stated that BHC is a nation model. The San Francisco Community Justice Center (CJC) created in 2009. The Center is geographically based court serving in the Tenderloin, Civic Center, and Union Square and SOMA neighborhoods. The Center is a court program and social service center that addresses the primary issues facing criminal defendants. Working in partnership with city agencies and community groups, the center values accountability and immediate intervention to prevent cycles of recidivism while improving the lives of CJC clients and community residents. A defendant at CJC has the same legal right as a defendant in criminal court.

The Wellness Court locates in the Juvenile Justice Center. The primary goal is to connect minors with severe emotional and developmental issues to the community-based providers and to receive appropriate services. GGRC (Golden Gate Regional Center) provides services and supports to minor with developmental disabilities. Minors who are confined in the Juvenile Justice Center are rarely sent to McCauley for involuntary treatment. Each year, only one to two minors are sent to hospital from the Center for acute inpatient psychiatric treatment.

A portion of the California Welfare & Institutional Code addresses community mental health services. The Lanterman Petris Short Act (LPS), California Welfare and Institutions Code Sections 5000-5550, cover the services and treatment provided to individuals who are found to be gravely disabled. The following hospitals such as CPMC, Langley Porter, St. Francis, SFGH and Jewish Home are designated facilities to provide involuntary treatment. Jewish Home provides treatment for geriatric patients who are gravely disabled and needs conservatorship services. Welfare and Institutions Code (WI Code) Section 5150 provides for a 72- hour hold for involuntary evaluation and treatment, and WI Code §5120 provides for a 14-day hold for further involuntary evaluation and treatment. A peace officer, mobile crisis team member, member of the staff evaluating facility, or other professional person as defined by the county may initiate 5150 hold. Minors with grave disability as a result of mental illness are not mixed with adults in terms of housing in a hospital setting. Each minor who is detained must receive a clinical multidisciplinary evaluation by properly qualified professionals, and the minor's family or living environment must also be evaluated; an after-care plan must be developed for each minor who is considered for release from involuntary treatment.

If the treatment team finds the patient is still gravely disabled, the team will file a recommendation and petition for temporary conservatorship (30 days). During the 30-day temporary conservatorship, if the patient is still found to be gravely disabled and unable to manage his or her basic needs such as food, clothing and shelter, a permanent conservatorship may be established. The duration for the permanent conservatorship is one year. It is renewable annually.

Community Independent Pilot Project (CIPP) is a pilot project, which provides individuals who are gravely disabled to be placed on LPS Conservatorship with community placement. Generally, the LPS conservatees are initially placed in civilian locked facilities for treatment and stabilization. LPS-CIPP is an innovative two-year program with about 7 participants. Before becoming director of CBHS, Jo Robinson was with JPS and brought CIPP to fruition to provide clients with both

conservatorship and medication therapy in the community rather than in a locked facility. The CIPP participants have the same legal right to judicial review provided by WI Code. The spirit of CIPP is to provide the least restrictive placement for the conservatees and the most humane way to help participants avoid cycles of de-compensation, which sometimes results in loss of independence and re-hospitalization.

Ms. Lewis asked about criteria for CIPP referrals.

Ms. Chien said that a client with multiple repeated hospitalizations in a short time period is one of the key criteria for CIPP referrals.

Ms. Robinson added that CIPP is a voluntary program with collaboration between the Office of Conservatorship Services, the Department of Public Health Placement Team, the Offices of the Public Defender and the District Attorney.. Other people include co-ordination with physicians and psychologists who specialize in mental health treatment, community mental health providers and the San Francisco Superior Court.

Ms. Robinson San Francisco provides three comprehensive crisis units working in the same building. Child Comprehensive Crisis located in BVHP (Bayview Hunter's Point) operates on a daily 24x7 schedule. Mobil Crisis responded to adults six-days per week until 11 PM, but they stop accepting call at 10 PM in order to adequately wrap up any currently outstanding crises. And the Crisis Intervention Response Team handles homicides and extreme violent cases.

Ms Miller asked if the comprehensive crisis system is different than CRN.

CRN is the Community Response Network to address youth gang violence issues by incorporating existing neighborhood services, funded programs and coordinating these efforts across programs and agencies. The CRN was founded in the Mission District in 2004. It is also known as the Southeast CRN. The Community Care Response Team is available for support at the crime scene, the hospital, in the home, or in the neighborhood. The CRN Initiative focuses its work in three core service areas:

- *Care management services and development*
- *Street level outreach*
- *Crisis response/healing strategies*

Ms Vinh asked about volunteer opportunities for crisis services.

Ms. Robinson said "No formal program for volunteers yet but we do have peer services".

3.2 Public comment

No public comment.

ITEM 4.0 ACTION ITEMS

For discussion and action

4.1. Public comment

No public comment.

4.2. PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of November 14, 2012 be approved as submitted.

Unanimously approved.

4.3 PROPOSED RESOLUTION: Be it resolved that the notes for the Mental Health Board Retreat on December 1, 2012 be approved as submitted.

Unanimously approved.

ITEM 5.0 REPORTS

5.1 Report from the Executive Director of the Mental Health Board.

Ms. Brooke announced that at the December 2012 Working Retreat the board decided to focus program reviews on programs and services in the Bayview Hunter's Point or the Southeast Sector of San Francisco.

She announced that at the December 7th, 2012 Consumer and Family Member Conference the board taped a video titled "Creating a Safe Space".

She also suggested to the board that any board member could do short public video on his/her board interests.

5.2 Report from the Chair of the Mental Health Board and the Executive Committee.

Ms. Argüelles hoped everyone had a pleasant holiday and are ready to meet with members of the Board of Supervisors and do program reviews. The retreat went very well. It was a beautiful location, great food and having Michelle Magee from the Harder Company donate her time to facilitate made it a very good experience for all.

The Executive committee meets Thursday, January 17th at 6:30 at 1380 Howard Street in Room 515. All board members are welcome to attend the meeting as well as members of the public.

5. 3 Report from Nominating Committee, Chair: Wendy James

Ms. Argüelles said that the nominating committee will announce the slate of officers nominated for 2013, to be voted on at the February 2013 meeting. Additional nominations can be made from the floor as well.

She said that Wendy James chaired the Nominating Committee which met in November 2012 to select a slate of officers to be elected in February 2013. She has termed out as Chair and additional nominations can be made from the floor as well.

No nominations from the floor were made today.

She also mentioned that the nominating committee decided to try something a little different this year so as to give more people the opportunity to develop leadership roles on the Mental Health Board. Instead of a single Chair and Vice Chair position, they nominated two co-chairs and two co-vice chairs, and one secretary. Here is the slate which will be voted on at the February 13th, 2013 meeting. Additional nominations can be made from the floor in February as well.

Co-Chairs: Virginia Lewis and Terence Patterson

Co-Vice Chairs: Ellis Josephs and Wendy James

Secretary: Dr. David E. Lewis

5.4 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

Ms. Argüelles asked if there are any people or issues that board members would like to suggest to the Executive Committee for highlighting at the November 2012 meeting.

Dr. David Lewis said he was contacted by a BART representative who would like to do a presentation to the board on AB716. He believed that AB716 implementation would give BART carte blanche to socio-profiling people with mental illness. And he is against AB716 because stigma and discrimination are being disguised as a public safety in BART's "Stay Away" Safety program. "How are non-violent people with mental illness being a threat to BART's public safety", he wondered!

5.5 Report by members of the Board on their activities on behalf of the Board.

Ms. Miller submitted the Trauma Summit report from the November 13, 2012 Trauma Summit. She reported that she met with Supervisor Malia Cohen and brought up issues that were mentioned in the summit.

Ms. Wishom reported that he, Mr. Vinh, Ms. Chien and Ms. Argüelles and board staff attended the December 7th 2012 Consumer and Family Member Conference.

Dr. Patterson reported that he will meet with Supervisor David Campos next week and plans to talk to the supervisor about findings at the Southeast Trauma Summit.

Ms. Lewis plans to meet her supervisor and would like to talk about the Southeast Trauma Summit with her supervisor.

Ms. Landy mentioned that San Francisco supervisors have a Face book presence and they can be contacted that way too.

5.6 New business - Suggestions for future agenda items to be referred to the Executive Committee.

Ms. Argüelles suggested an invitation to the BART representative to the January 17th, 2013 Executive Committee meeting.

5.7 Public comment.

No public comment.

ITEM 6.0 PUBLIC COMMENT

No public comment.

ADJOURNMENT

Meeting adjourned at 8:15 PM.

OVERVIEW OF ADULTS AND JUVENILES IN CRISIS

INTERACTING WITH
THE CRIMINAL JUSTICE SYSTEM &
THE MENTAL HEALTH SYSTEM



CRIMINAL JUSTICE SYSTEM

- Jail Psychiatric Services
 - Housing
 - Treatment
 - Referral for services
- Incompetent to stand trial
 - Adults
 - Juveniles

CRIMINAL JUSTICE SYSTEM

- BEHAVIORAL HEALTH COURT (BHC)
 - Eligibility – Axis 1 diagnosis
 - Program entry is at the discretion of the District Attorney
 - Limited to criminal cases in which the behavior that led to the offense was related to mental illness

CRIMINAL JUSTICE SYSTEM

- THE SAN FRANCISCO COMMUNITY JUSTICE CENTER (CJC)
 - Tenderloin, Civic Center, Union Square and SOMA neighborhoods
 - Format - court program and social service center
 - Goals – accountability and immediate intervention to prevent cycle of recidivism

CRIMINAL JUSTICE SYSTEM

- WELLNESS COURT
 - Juvenile Justice Center
 - Minors with severe emotional and developmental issues

PSYCHIATRIC COURT

- California Welfare & Institutions Code
- Lanterman-Petris-Short Act (LPS Act)
 - Individuals who are gravely disabled
 - Who are in need of treatment but are unwilling or incapable of accepting it voluntarily; and
 - Who are recommended for conservatorship by the professional in charge of an LPS evaluation or treatment facility designated by the county

PSYCHIATRIC COURT

- WI CODE §5150 – 72 hour hold
- Legal criteria – “Grave disability” defines as “ a condition in which a person, as a result of mental disorder, is unable to provide for his or her basic personal needs for food, clothing, or shelter.”

PSYCHIATRIC COURT

- WI Code §5250 – additional 14 day hold for further treatment
- Legal criteria – The patient is, as a result of mental disorder or impairment by chronic alcoholism, a danger to others, or to himself or herself, or gravely disabled.

PSYCHIATRIC COURT

- Temporary Conservatorship (WI Code §5352.1)
- Legal criteria – Any person who is gravely disabled as a result of a mental disorder, or impaired by chronic alcoholism.

PSYCHIATRIC COURT

- Permanent Conservatorship
 - Conservatorship based on “graved disability”
 - Conservatorship based on “a substantial risk of harm to others” (a.k.a. Murphy Conservatorship)
 - a trial incompetent defendant is found not to have a substantial likelihood to regain trial competence

PSYCHIATRIC COURT

- LPS CONSERVATORSHIP – COMMUNITY INDEPENDENT PILOT PROJECT (CIPP)
 - Conservatee lives in community
 - Conservatee does not have a right to refuse psychiatric medication
 - Conservatee works closely with his or her case manager and outpatient team
 - Conservatee checks in regular with the presiding judge regarding his or her progress







SAN FRANCISCO MENTAL HEALTH BOARD

Mayor Edwin Lee

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, February 13, 2013
Department of Public Health
101 Grove Street
Room 300
6:30 – 8:30 PM

CALL TO ORDER

ROLL CALL

AGENDA CHANGES

Item 1.0 DIRECTORS REPORT

For discussion.

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public Comment

Item 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

For discussion.

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Updates

2.2 Public Comment

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Item 3.0 PUBLIC HEARING ON AB716: BART (BAY AREA RAPID TRANSIT) HAS NEW AUTHORITY TO PROTECT RIDERS AND EMPLOYEES AND IS SEEKING PUBLIC INPUT BEFORE IMPLEMENTING AB716. SPEAKERS: BART POLICE LIEUTENANT, TYRONE FORTE; BART POLICE CRISIS INTERVENTION COORDINATOR, ARMANDO SANDOVAL; AND BART MANAGER OF GOVERNMENT AND COMMUNITY RELATIONS, RODDRICK B. LEE

For discussion

3.1 Presentation: Public Hearing on AB716: BART (Bay Area Rapid Transit) has new authority to protect riders and employees and is seeking public input before implementing AB716. Speakers: BART Police Lieutenant, Tyrone Forte; BART Police Crisis Intervention Coordinator, Armando Sandoval; and BART Manager of Government and Community Relations, Roddrick B. Lee

3.2 Public comment

Item 4.0 ACTION ITEMS

For discussion and action.

4.1 Public comment

4.2 . PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of January 9, 2013 be approved as submitted.

Item 5.0 REPORTS

For discussion and possible action.

5.1 Report from the Executive Director of the Mental Health Board.
Discussion regarding upcoming events, conferences, or activities that may be of interest to board members; Mental Health Board budget issues and update on staff work on board projects.

5.2 Report of the Chair of the Board and the Executive Committee.
Discussion regarding Chair's meetings with Community Behavioral Health Services staff, meetings with members of the Board of Supervisors and community meetings about mental health or substance abuse.

5.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

5.4 Report by members of the Board on their activities on behalf of the Board.

5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

5.6 Public comment.

Item 6.0 PUBLIC COMMENT

ADJOURNMENT

DISABILITY ACCESS

1. Room 278 is accessible to persons using wheelchairs and others with disabilities. Assistive listening devices, materials in other alternative formats, American Sign Language interpreters and other accommodations will be made available upon request. Please contact Darlene Daevu, Community Behavioral Health Services, 415-255-3426 or by email: Darlene.daevu@sfdph.org. Providing at least 72 hours notice will help to ensure availability. To reach a TTY line, call (415) 255-3449. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.
2. Meetings are held at City Hall, One Dr. Carlton B. Goodlett Place (between Grove and McAllister), in Room 278. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 71 Haight/Noriega. Also, the J, K, L, M, and N lines underground. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.
3. Special Hearings are usually held at the Department of Public Health, 101 Grove Street, 3rd Floor, Room 300. The same public transportation options as above apply. It is wheelchair accessible.
4. For Special Hearings at other locations, please call for directions or bus information. All locations will be accessible.
5. City Hall is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on One Dr. Carlton B. Goodlett Place.
6. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: sotf@sfgov.org

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from the Task Force or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: www.sfgov.org/sunshine

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: www.sfgov.org/mental_health. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

Lobbyist Registration and Reporting Requirements

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics



Edwin Lee
Mayor

SAN FRANCISCO MENTAL HEALTH BOARD

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Unadopted Minutes

Mental Health Board

Wednesday, February 13, 2013

DPH, 101 Grove Street, Room 300

San Francisco, CA

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BOARD MEMBERS PRESENT: M. Lara Siazon Argüelles, Chair; David Elliott Lewis, Ph D, Secretary; Kara Chien, JD; Sgt. Kelly Dunn; Virginia S. Lewis, LCSW, MA; Terence Patterson, EdD, ABPP; Alphonse Vinh, MS; Errol Wishom.

BOARD MEMBERS ON LEAVE: Ellis Joseph, MBA, Vice Chair; Wendy James; and Alyssa Landy, MA; and Lena Miller, MSW.

BOARD MEMBERS ABSENT: Lynn Fuller, JD.

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jo Robinson, Director of Community Behavioral Health Services (CBHS); Kenton Rainey, Chief of BART Police; Tyrone Forte, BART Police Lieutenant; Armando Sandoval, BART Police Crisis Intervention Coordinator; and Rodrick B. Lee, BART Manager, Government and Community Relations; Crystal Raine, Community Oriented Policing Unit Office of the Chief; Michelle Schultz, MHA-SF (Mental Health Association of San Francisco); Kaye Griffin, AMN Press; Terry Bohrer, MHA-SF; Greg Holland; Mathew Teen, Conard House Shelter Monitor Committee; John Alex Lowell, Pedestrian Safety Advisory Committee; Marlene Flores; and eight members of the public.

CALL TO ORDER

Ms. Argüelles called the meeting of the Mental Health Board to order at 6:42 PM.

ROLL CALL

Ms. Brooke called the roll.

AGENDA CHANGES

There were no changes to the agenda.

ITEM 1.0 DIRECTOR'S REPORT

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

Please see the attached February 2013 Director's report.

Monthly Director's Report
February 2013

1. Mental Health Loan Assumption Program (MHLAP) for fiscal year 2012-2013

Congratulations to the FY12/13 Mental Health Loan Assumption Program Award Recipients! The Health Professions Education Foundation received 71 San Francisco applications and 26 were selected as awardees.

The MHLAP encourages mental health providers to practice in underserved locations in California by authorizing a plan for repayment for some or all of their educational loans in exchange for their service in a designated hard-to-fill/retain position in the Public Mental Health System. The MHLAP is administered by the Health Professions Education Foundation (www.healthprofessions.ca.gov), and is funded through the Workforce Education and Training component of the Mental Health Services Act.

2. President's Plan to Reduce Gun Violence Calls Attention to Mental Health Issues

Last month (1/16/13), President Obama released a package of proposals to reduce gun violence and a list of gun violence reduction executive actions. Among the 23 Executive Orders signed on Wednesday are a number of key components related to mental health. Foremost, the President's Plan, *Now Is the Time: The President's Plan to Protect our Children and our Communities by Reducing Gun Violence*, calls for stronger prevention and early intervention efforts to identify and treat mental health and substance use disorder issues early. Such efforts are to include bolstering access to mental health services in schools and encouraging teachers to intervene early when they believe a student needs counseling. Additionally, the plan calls for long-awaited rules requiring insurance companies to cover mental health services, including finalizing regulations clarifying parity requirements.

Specifically, the President's Plan includes the following key proposals relevant to mental health:

- "Mental Health First Aid" training for teachers. \$15 million proposed for training for teachers and other adults who interact with youth to detect and respond to mental illness in children and young adults, including how to encourage adolescents and families experiencing these problems to seek treatment. Also proposes \$40 million to help school districts work with law enforcement, mental health agencies, and other local organizations to assure students with mental health issues or other behavioral issues are referred to the services they need.
- Support for transition-age youth. \$25 million proposed for innovative state-based strategies supporting young people ages 16 to 25 with mental health or substance abuse issues.

- Helping schools address pervasive violence. \$25 million proposed to offer students mental health services for trauma or anxiety, conflict resolution programs, and other school-based violence prevention strategies.
- Train more than 5,000 additional mental health professionals to serve students and young adults. \$50 million proposed to train social workers, counselors, psychologists, and other mental health professionals. This would provide stipends and tuition reimbursement to train more than 5,000 mental health professionals serving young people in our schools and communities.
- Launch a national conversation to increase understanding about mental health. The President is directing Secretaries Sebelius and Duncan to launch a national dialogue about mental illness with young people who have experienced mental illness, members of the faith community, foundations, and school and business leaders.
- Finalize requirements for private health insurance plans to cover mental health services. The Administration will issue final regulations governing how existing group health plans that offer mental health services must cover them at parity under the Mental Health Parity and Addiction Equity Act of 2008. In addition, the Affordable Care Act requires all new small group and individual plans to cover ten essential health benefit categories, including mental health and substance abuse services. The Administration intends to issue next month the final rule defining these essential health benefits and implementing requirements for these plans to cover mental health benefits at parity with medical and surgical benefits.
- Make sure millions of Americans covered by Medicaid get quality mental health coverage. The Administration has issued a letter to state health officials making clear that these plans must comply with mental health parity requirements.

California's Senate President Pro Tempore, Senator Steinberg, also reached out to Vice President Biden to propose a framework for the federal role in investment in mental health services, requesting the federal government augment mental health funding by \$10 billion for Prop. 63-like services throughout the nation. The Pro Tempore, accompanied by California Institute for Mental Health Chief Executive Office Sandra Naylor-Goodwin, will be presenting his proposal to the Vice President early next week in Washington, DC.

3. January marked the Continued Implementation of some Critical Policy and Programmatic Initiatives

Katie A. Human Services Agency and CYF, CBHS will be hosting a two day summit on March 4th and 5th to align and develop our plan for enhancing the Foster Care mental health system for youth at risk of or in residential or hospital placements. The summit will include Juvenile Probation, Education, CBHS and HSA as well as providers currently providing intensive services to foster care youth. The focus of the meeting will be on understanding the mandate, evaluating our current service system, aligning our principles and practices and developing a working map of our preferred service system. The product of the summit will be a clear timeline and workplan as well as designated workgroups to enhance and develop the services.

ERMHS: This month SFUSD and CBHS and completed the memorandum to provide services to qualified youth. CYF is currently working closely with SFUSD on developing screening, assessment and treatment models that are consistent with the SFUSD mission meet legal mandates

incorporated into the IEP and constitute best behavioral health practices. As we move forward we will continue to discuss our model of care to insure we are helping students improve their educational experience by attending to their social-emotional needs.

Trauma-Informed Care: The CBHS core group continues to meet to discuss curriculum and delivery mechanisms to begin to develop trauma informed training for Community Programs. The current focus is on collecting information on what other systems have done and incorporating that into our current plan. We are intending to have a draft curriculum and plan by the end of June and hope to vet that plan through the summer. The intention is to begin piloting the initiative in September 2013.

Providers: CYF providers will be meeting in early February to discuss the structure and purpose of the providers meeting. The plan is to determine how to best incorporate strategy discussions, review of outcome data and policy and procedural issues into one monthly meeting.

CYF Leadership: The CYF leadership team is currently working on developing a way of acknowledging staff, programs, services and agencies that have effectively served the children, youth and families. The goal is to be able to identify, support, acknowledge and celebrate success and to help individuals and programs spread that success to their colleagues and sister agencies.

4. Formation of Comprehensive Crisis Services

In August 2011, after many months of planning, the three civil service crisis programs (the Comprehensive Child Crisis, Crisis Response, and Mobile Crisis Treatment Teams) began integrating under the banner of "Comprehensive Crisis Services."

The purpose of this integration has been to create financial and staffing efficiencies and then to translate them into bolstered existing care, as well as, potential service expansion. Although unified under a new name/ leadership structure, each program would retain its original clinical identity.

This process has included unifying the clinical and administrative leadership of the programs, adjusting the clinical staffing patterns, and implementing the cross-training of select staff across the three service modalities.

Under the supervision of John Grimes, Stephanie Felder, Therese Garrett, and David Pine, the initial efforts focused on the Child Crisis and Crisis Response services, which already enjoyed a close programmatic relationship and shared an office space in the Bayview Plaza. The plan took a major step forward when, in December 2011, the Mobile Crisis Team relocated from its office in the South of Market neighborhood into this same suite.

In the following months, the staff adjusted to the new co-location arrangements, the leadership continued to fine-tune the integration plans (with input from all program staff), and the cross-training of new hires and interested existing staff began.

The Child Crisis and Crisis Response programs operate 24/7 and can be reached at 415-970-3800. The Mobile Crisis Team operates weekdays 8:30am to 11pm and Saturdays/ holidays from 12pm to 8pm. Its new number is 415-970-4000.

The Comprehensive Child Crisis, Crisis Response, and Mobile Crisis Teams are now co-located at 3801 Third Street, Suite 400, San Francisco 94124. *(Please note that Mobile Crisis still only evaluates clients in the field. Please do not direct clients to their office).*

5. Health and Human Services Secretary, Kathleen Sebelius, wrote an opinion for USA Today on mental illness: Bring mental illness out of the shadow

Please see the following link to the 2/4/2013 story:

<http://www.usatoday.com/story/opinion/2013/02/04/kathleen-sebelius-on-mental-health-care/1890859/>

6. CiMH Learning Collaborative - Advancing Recovery Practices (ARP) Summary of FSP Graduation Team Work

Since January of 2012, CBHS has had two teams participating in the 13-month long Advancing Recovery Practices (ARP) Learning Collaborative sponsored by CiMH. Based on the practical training program of the Institute for Healthcare Improvement (IHI) Model for Improvement, the ARP teams created small tests of change using the Plan-Do-Study-Act (PDSA) framework, over several months, from which they gathered data and made changes in programs to enhance recovery practices.

The Office of Quality Management partnered with Citywide Forensics FSP and SOMMHS to focus on identifying clients nearing readiness for graduation, supporting their transition out of the FSP and linking them effectively to outpatient services. To that end, the FSP Graduation team developed Talking Points for recovery conversations; utilized the Strengths Assessment, Strengths based Group Supervision and Personal Recovery Plan from Kansas University School of Social Welfare (R Goscha); developed a 22-item Recovery Checklist; and piloted a roadmap for client transitions called the Linkage Process.

Highlights of Learning from the FSP Graduation Team:

- Client conversations about recovery and “graduation” are best as early as possible after enrollment
- Peer specialists are key players in helping to:
 - o Make clients feel welcome in a new setting
 - o Model client self-advocacy and recovery
 - o Connect clients to non-mental health community-base activities
- Focusing on client’s strengths builds both client and provider hope for recovery
- Newly developed 22-item Recovery Checklist helps:
 - o see a client’s recovery progress and needs more clearly
 - o focus on key recovery areas that need support before graduating out of the FSP
 - o provide a communication tool for understanding the client’s recovery that can be shared
 - between client and provider

- between FSP and outpatient providers during linkage

Next month, both teams, FSP Graduation and Team OMI, end their formal participation with CiMH and strike out on their own with all the recovery-based knowledge, tools and practices gained from this rich program improvement opportunity, with an eye toward expansion to other programs:

- Expand use of the Recovery Checklist to other FSP and ICM programs
- Develop an age-appropriate Recovery Checklist with the Child/Youth/Family (CYF) programs
- Both ARP teams will meet monthly with CBHS Leadership and key program directors to work on spread of ARP-informed, recovery-oriented tools and practices across the SOC.

CiMH will initiate the next ARP Learning Collaborative later this year. This offers an opportunity for other CBHS programs to take advantage of their structured model, extensive training and tools in order to test and implement recovery-based program changes, leading to improvements in clients' well-being and outcomes.

7. Adult Transgender Cultural Competence and Cultural Humility: 101

February 21, 2013 from 1:00-4:30pm

Location: SFGH Carr Auditorium - 1001 Potrero Ave. Building 3

This workshop is designed to educate service providers on important issues and trends affecting transgender people and their families. This workshop will address several key issues related to the health and wellness of the transgender communities. The primary goals of the workshop are to enhance the skills of service providers to provide culturally competent and welcoming services to transgender individuals and to expand the clinical knowledge and comfort level of medical, social and mental health care professionals, and frontline staff (security guards, receptionists, MD's, and therapists) in order to provide quality care to transgender individuals. The training will consist of viewing Transgender Tuesdays, a movie that documents the experience of SF Transgender patients at Tom Waddell Health Center and prior to the ability to obtain gender sensitive health care. It will also have two separate panel discussions and a presentation on the why and how to be a more welcoming clinic and provide a higher quality of care to our community.

8. Council of State Governments Features San Francisco in its Study on the Impact of Probation and Parole in Arrests

As local governments are having to content with the fiscal pressures of reducing costs associated with the criminal justice system, the Council of State Governments has initiated a comprehensive study on the effects of probation and parole supervision on arrest rates. San Francisco, along with Los Angeles, Redlands, and Sacramento participated in this effort. A key takeaway from this study is that about one in five people arrested in these four metropolitan areas were under parole or probation supervision when they came into contact with police. And that when compared to the 80% of arrests that did not involve people under community supervision, people under probation and parole supervision made up a disproportionately large share of drug arrests. The report is available at the Council of State Governments website: <http://justicecenter.csg.org/> (See attachment 1)

9. Gloria Wilder Selected to Attend American Society of Health-System Pharmacy Leadership Institute

Congratulations to Gloria Wilder, Director of CBHS Pharmacy. Gloria was selected for the ASHSP's Foundation Pharmacy Leadership Institute. The Pharmacy Leadership Institute is a challenging program designed to develop inspirational leaders, energize accomplished clinicians and managers with new insights and equip participants for the roles of executive leader, coach, teacher, motivator and strategist. Participants will have opportunities to share their expertise, complementary skill sets and work and life perspectives with each other. Widely recognized and highly regarded within the health-system pharmacy community, alumni enjoy an established network of the best and brightest pharmacy leaders across the country. The program is taught at Boston University's prodigious business school by tenured professors. We look forward to Gloria's participation in the ASHS Leadership Institute. Community Behavioral Health Services greatly appreciated Gloria for her wisdom and her leadership.

10. The Mental Health Services Act Housing Program in San Francisco

The San Francisco Department of Public Health (SFPDH) has used Mental Health Services Act (Prop 63 or MHSA) housing funds to create permanent supportive housing and services for individuals with serious mental illness who are homeless or at risk of being homeless. All tenants have leases and maintain independent housing with the support provided through MHSA, the sponsors, and SFPDH.

Development Project Summary Cost Allocations

SF MHSA Housing Funding				
Income	Capital	Subsidy	Discretionary	Total
MHSA Allocation	\$5,142,900	\$2,571,500		\$7,714,400
Discretionary Fund Transfer			\$2,163,000	\$2,163,000
Interest			\$281,514	\$281,514
Total				\$10,158,914
SF MHSA Housing Funded Projects				
Polk and Geary	\$1,000,000			\$1,000,000
Richardson	\$1,200,000	\$1,200,000		\$2,400,000
Veterans Commons	\$800,000			\$800,000
Kelly Cullen Community	\$1,700,000	\$1,700,000		\$3,400,000
Ocean Avenue	\$600,000	\$600,000		\$1,200,000
Rene Cazenave	\$1,000,000			\$1,000,000
Admin Fees				\$98,776
Total	\$6,300,000	\$3,500,000		\$9,898,776
Balance*				\$260,138

*Balance to be allocated to reserve additional units in an existing MHSA housing project.

MHSA Housing Development: Completed

Project	Address	Sponsor	Total Units	MHS A Units	Population
Polk and Geary Senior	990 Polk	TNDC/Citizens	110	10	Seniors
Richardson Apartments	365 Fulton Street	CHP/Mercy	120	12	Adults
Veterans Commons	150 Otis	CCDC/Swords	76	8	Adults (Vets)
Kelly Cullen Community	220 Golden Gate	TNDC	174	17	Adults
Ocean Avenue	1100 Ocean Ave.	BHNC/Mercy	60	6	Youth
Rene Cazenave	530 Folsom	CHP/BRIDGE	120	10	Adults
Total				63	

Project Descriptions Completed Projects



The Polk and Geary senior building,

built in partnership with Citizens Housing Corporation, represents an innovative approach to address homelessness by combining services-rich supportive housing units within a larger low-income population. The property was voted the overall winner in the national Readers' Choice Awards for Affordable Housing Finance Magazine in 2009. Its ground floor contains retail spaces and offices for resident services providers. A large community room and kitchen, computer center, laundry room, solarium and outdoor patio are accessible from the second floor. Another outdoor patio is located on the seventh floor, and on the eighth floor residents can plant their own fruits and vegetables in a community garden.

In the community room, residents can participate in educational programs and activities or reserve the space for a special event. Ten of the units are fully accessible, and the remaining units are adaptable for individuals with disabilities. 50 units are set aside for formerly homeless seniors; the rents and services for residents of these units are subsidized by the City of San Francisco. 990 Polk was also one of the first new construction projects to receive funding from the MHSA Housing Program.

Drs. Julian and Raye Richardson Apartments, opened in 2011, is a five-story development including 120 studio units of housing for extremely low income, formerly chronically homeless

individuals. Located at the corner of Fulton & Gough streets, the building also includes ground floor retail commercial space, common space and social service program space. Additionally there is an open courtyard and roof deck open space area. Twelve units are designated for the MHSA Housing Program. An integrated services team provides the community with a full range of on-site and off-site resources, including community-building events, educational opportunities, information and referrals to local social services, health management support by a visiting nurse practitioner or mobile medical team, case management and crisis prevention and intervention. The University of California-San Francisco Citywide Case Management team works with SFDPH's Housing and Urban Health Clinic (HUHC) and three adult Full Service Partnerships (FSPs) to provide the 12 MHSA residents with integrated recovery and treatment services appropriate for severely mentally ill adults to help them live in the community and to maintain the greatest possible independence, stability and level of functioning. The property is managed by Community Housing Partnership.



Veterans Commons, opened in 2012, is an adaptive reuse of a 9-story steel-frame and concrete structure at 150 Otis Street in San Francisco. The building was originally constructed in 1916 as the City's first Juvenile Court and Detention Home, but now consists of permanent, affordable rental housing with on-site

supportive services for homeless veterans. The project houses 76 U.S. veterans, eight of whom qualify for the MHSA Housing Program. Veterans Commons accommodates veterans in studio apartments, each with a private bath and kitchen. The development includes space for intensive supportive services designed to build community and stability among residents, including space for counseling, group meetings, case management, and social activities. Veterans Commons has a dedicated, on-site supportive services team with accessible offices, private meeting rooms, and an exam room for visiting nurses, or other community health practitioners. Adult Full Service Partnerships provide the 8 MHSA residents with integrated recovery and treatment services appropriate for severely mentally ill adults to help them live in the community and to maintain the greatest possible independence, stability and level of functioning. The property is managed by Swords to Plowshares.

Kelly Cullen Community is a \$95 million renovation of the former Central YMCA at 220 Golden Gate and provides 172 efficiency studio units for chronically homeless individuals. Completed in 2012, the project includes a ground floor SFDPH-managed health and wellness clinic and a corner commercial retail space. Unique historic features restored include the 2nd floor atrium and auditorium, and a 5th floor gymnasium. Operated by the Tenderloin Neighborhood Development Corporation (TNDC), Kelly Cullen is named after one of the first executive directors of TNDC, Brother Kelly Cullen, who came to the Tenderloin in 1981 with the idea of ministering to the poor, and helped transform TNDC from the fragile and fledgling organization of its roots to the thriving neighborhood institution it is today.

Projects in Development

The **Ocean Avenue** development is a new construction project that will include 70 units of housing for families and transitional aged youth (TAY) and one property manager unit. The ground floor will feature commercial space designed to complement the existing neighborhood and enhance the

shopping experience on Ocean Ave. The building will consist of a mix of studios, 1, 2, and 3-bedroom units available to residents making no more than 50% of the area median income. Twenty-five units will be restricted at 20% of the area median income. It is anticipated that this project will start construction in mid-2013, with a seventeen month construction period.

Six (6) of the project's 25 TAY units will be reserved for the MHSA Housing Program. An integrated services team will provide the youth community with a full range of on-site and off-site resources, including community-building events, educational opportunities, information and referrals to local social services, case management and crisis prevention and intervention. In addition, Community Behavioral Health Services, will work with property management and two TAY Full Service Partnerships to provide the 25 TAY residents with integrated recovery and treatment services appropriate for severely mentally ill youths to help them live in the community and to maintain the greatest possible independence, stability and level of functioning. The property will be managed by Mercy Housing Management Group, an affiliate of Mercy Housing California.

The **Rene Cazenave** Apartments will be a new housing project in the Transbay Redevelopment Area developed by Community Housing Partnership and BRIDGE Housing. Following completion of the project, Community Housing Partnership will remain the owner and property manager of the site. The building will be named in memory of Rene Cazenave – a founding board member of Community Housing Partnership who was at the center of the affordable housing movement in San Francisco for over 40 years. Leddy Maytum Stacy Architects is the architect for the project.

Rene Cazenave Apartments will be a mid-rise, eight-story building. The proposed design includes 120 apartments, of which 12 are 1-bedroom units and 108 are studios. Ten of the units will be reserved for MHSA clients. Ground floor spaces include a wide range of programming space, private courtyard, and two retail spaces. All tenants will be formerly homeless and referred by SFDPH. The site is located on Folsom Street at the northeast corner of Essex Street. Rene Cazenave Apartments is the first of several development sites in the San Francisco Redevelopment Agency Transbay Redevelopment Area and will serve as a gateway to the SFRA's vision of a new "main street" along Folsom Street.

Other MHSA Housing Projects

Aarti: The only county in the state to use MHSA dollars beyond the housing allotment for permanent units, San Francisco allocated additional General System Development funds to develop housing for transition aged youth with Larkin Street Youth Services. In 2009, Larkin Street began planning with TNDC and SFDPH to expand the Routz program, which provides housing and wraparound support services for those in our care with the greatest mental health needs. Capacity to house youth through Routz will more than double when youth begin moving into the Aarti Hotel this fall. TNDC will provide property management and Larkin Street will offer case management, therapeutic services, and other wraparound supports to help residents address their mental health and build critical life skills. The Aarti is home to 40 youth between the ages of 18 and 24, and Larkin offers ten youth scattered-site apartments in the community.

11. House Democratic Task Force Issues Policy Principles on Gun Violence Prevention; Includes Closing Holes in the Mental Health System (CMHDA)

http://bobbyscott.house.gov/images/stories/Gun_Violence_Prevention_Task_Force_Recommendations.pdf

Congressman Mike Thompson (CA-5), chair of the Democratic Caucus House Gun Violence Prevention Task Force, today announced the task force's comprehensive set of policy principles designed to reduce gun violence "while respecting the 2nd Amendment Rights of law-abiding Americans." Most of the principles were related specifically to the purchase of guns. However, the following principle related to mental health was also included:

"Close the holes in our mental-health system and make sure that care is available for those who need it: Congress must improve prevention, early intervention, and treatment of mental illness while working to eliminate the stigma associated with mental illness. Access to mental health services should be improved, the shortage of mental health professionals should be addressed, and funding should be made available for those programs that have proven to be effective."

The task force met with and solicited input from victims of gun violence and gun safety advocates; gun owners, hunters, and outdoor sportsmen; federal, state, and local law enforcement; educators and community workers; mental health experts and physicians; representatives of the motion picture, television, music, and video game industries; leaders in our faith communities; and representatives of gun manufacturers and retailers, as well as cabinet secretaries and the Vice President of the United States. The task force also met with Members of Congress from all sides of the issue, and held hearings in Washington, DC to consider ways to address this issue. It now urges Congress to take steps to act on the recommendations.

12. Senator Franken Introduces Mental Health in Schools Act (CMHDA)

Senator Al Franken (D-Minn.) last week introduced the Mental Health in Schools Act, to ensure that schools provide access to critical mental health treatment for children who need and deserve these services. Senator Franken's bill would authorize funding for grants to schools and community mental health centers to work with community-based organizations to expand access to mental health services for students. It will soon be introduced in the House of Representatives by Rep. Grace Napolitano (D-Calif.), who has introduced similar measures in the past. The bill is cosponsored in the Senate by Sens. Dick Durbin (D-Ill.) and Max Baucus (D-Mont.), Ben Cardin (D-Md.), Mazie Hirono (D-Hawaii), Sherrod Brown (D-Ohio), Mary Laddieu (D-La.), Richard Blumenthal (D-Conn.), and Jon Tester (D-Mont.).

The Mental Health in Schools Act would establish a grant program that would:

- Expand access to mental health services in schools;
- Support schools that work with community-based organizations to expand access to mental health services for students;
- Provide assistance through grants to schools to train staff, volunteers, families, and other members of the community to recognize the signs of behavioral health problems in students and refer them for appropriate services; and

- Authorize \$200 million in grant funding per year over five years, and eligible schools may apply for up to \$1 million per grant year, based on the size of their student population.

13. Substance Abuse

A recent report from the Center for Substance Abuse Research (CESAR) has shown a marked increase in Emergency Room (ER) visits related to the opiate treatment medication Buprenorphine from 2005 through 2010 (see attached article). Based on data from the SAMHSA Drug Abuse Warning Network (DAWN), buprenorphine related ER visits have risen steadily since this medication became available in the mid-2000s following the passage of the federal Drug Abuse Treatment Act (DATA 2000).

The report suggests that some of these ER visits may be related to "patients who may be attempting to self-treat opioid dependence using buprenorphine without a prescription" and that "expanding access to treatment and putting these patients in the care of a certified physician may help reduce the nonmedical use of buprenorphine and subsequent ER visits."

San Francisco County's Alcohol and Drug Administrator recently presented data from the same time period at the NIDA Community Epidemiological Working Group from DAWN showing that San Francisco is NOT showing this increase despite the widespread availability of buprenorphine treatment in the County (see attachments 2 and 3).

Since 2003, San Francisco has provided free or low cost access to opiate treatment with buprenorphine to low income opiate-addicted San Francisco residents through the Integrated Buprenorphine Intervention Service (IBIS) and its centralized medication initiation service, the Outpatient Buprenorphine Induction Clinic (OBIC). Located at 1380 Howard Street, OBIC provides assessment, initiation, stabilization and coordination services for patients who need medication assisted treatment with buprenorphine. OBIC works with more than 20 Primary Care, Mental Health and Substance Abuse treatment programs across the city to coordinate referrals of patients needing care, and has served more than 750 individuals. OBIC was the first buprenorphine induction clinic in the United States, and its model has now been replicated in other areas.

San Francisco supports appropriate and timely access to opiate addiction treatment that is integrated with other needed health services through innovative programs like IBIS and OBIC which will celebrate a decade of service this spring. Access to care can reduce or prevent negative consequences of drug addiction, such as drug-related ER visits.

Dr. Gleghorn will present the full CEWG report on Wednesday, February 27, 2013 from 1-2pm, everyone is welcome to attend. OBIC services may be accessed through Matt Tierney at (415) 255-4787.

14. Webinar Invitation: California Code of Regulations – Title 22 – Drug Medi-Cal – Beneficiary Record Requirements

You are invited to join the postservice postpayment (PSPP) utilization review unit for a webinar training on the Drug Medi-Cal (DMC) Requirements for Outpatient Drug Free, Day Care Habilitative, and Perinatal modalities. To register, please see the information below.

Title: California Code of Regulations – Title 22 – Drug Medi-Cal – Beneficiary Record Requirements

Topics: Postservice Postpayment (PSPP) reviews, Admission/Physical Exam, Treatment Plans, Counseling (Group and Individual), Continuing Service Justification, Discharge, Multiple Services, and Common Deficiencies.

Date: February 26, 2013

Time: 1:00PM – 3:00PM PST

Reserve your Webinar seat now at: <https://www1.gotomeeting.com/register/730605873>
Space is limited.

System Requirements:

PC-based attendees

Required: Windows 7, Vista, XP or 2003 Server

Mac-based attendees

Required: iPhone, iPad, Android phone or Android tablet

15. Attitudes Toward Mental Illness -- Results From the Behavioral Risk Factor Surveillance System

This study found that most adults surveyed agree that mental illness treatment is effective, but substantially fewer adults agreed that people are caring and sympathetic to people with mental illness. In general, adults with mental illness symptoms, including those receiving treatment for a mental health problem were less likely to agree that people are caring and sympathetic to people with mental illness. The report states, “Attitudes and beliefs about mental illness are shaped by personal knowledge about mental illness, knowing and interacting with someone living with mental illness, cultural stereotypes about mental illness, media stories, and familiarity with institutional practices and past restrictions. When such attitudes and beliefs are expressed positively, they can result in supportive and inclusive behaviors. When such attitudes and beliefs are expressed negatively, they may result in avoidance, exclusion from daily activities, and, in the worst case, exploitation and discrimination. For the full study, go to

www.cdc.gov/hrqol/Mental_Health_Reports/mental_health_reports.html

Let us all work to reduce stigma.

Past issues of the CBHS Monthly Director's Report are available at:

<http://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSdirRpts.asp>

To receive this Monthly Report via e-mail, please e-mail reanna.albert@sfdph.org

1.2 Public Comment

No public comment.

ITEM 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Updates

Ms. Robinson announced that she wanted to keep her director's report very brief in order to give more time to the BART presentation on AB 716.

She reported one of the Obama 2013 administration's key proposals is mental health first aid trainings for teachers.

She informed the board that March 4 to March 5 is a two day summit on Katie A law. The summit is hosted by CBHS (Community Behavioral Health Services), HSA (Human Services Agency) and CYF (Children, Youth and Families).

She also mentioned that California Senate President pro Tempore Darrell Steinberg praised San Francisco's MHSA Housing Program.

2.2 Public comment

No public comment.

ITEM 3.0 PUBLIC HEARING ON AB716: BART (BAY AREA RAPID TRANSIT) HAS NEW AUTHORITY TO PROTECT RIDERS AND EMPLOYEES AND IS SEEKING PUBLIC INPUT BEFORE IMPLEMENTING AB716. SPEAKERS: BART POLICE LIEUTENANT, TYRONE FORTE; BART POLICE CRISIS INTERVENTION COORDINATOR, ARMANDO SANDOVAL; AND BART MANAGER OF GOVERNMENT AND COMMUNITY RELATIONS, RODDRICK B. LEE

3.1 Public Hearing on AB716: BART (Bay Area Rapid Transit) has new authority to protect riders and employees and is seeking public input before implementing AB716. Speakers: BART Police Lieutenant, Tyrone Forte; BART Police Crisis Intervention Coordinator, Armando Sandoval; and BART Manager of Government and Community Relations, Roddrick B. Lee

AB 716 Fact Sheet is attached to the end of the minutes

Ms. Argüelles introduced Roddrick Lee, BART Manager of Government and Community Relations, and BART Police Lieutenant, Tyrone Forte, and BART Police Crisis Intervention Coordinator, Armando Sandoval. She said they will provide an overview of AB716, which allows BART to issue "stay away" orders to people who are cited or arrested for certain offenses, and they will explain the details and the public will be able to comment afterward.

BART Police Chief Kenton stated that the AB 716 is BART's response to acts of violence against BART frontline employees. He hoped that AB 716 will serve as a deterrent.

Mr. Lee stated there was a wide dissemination of AB 716 to about 600 community organizations, the general media in San Francisco and the East Bay, BART website, and posted at BART stations.

BART Police Lt. Forte mentioned a few violations, though not limiting to them only, that could result in a "stay-away" citation. Violations are assaults, battery or threatening acts, sex soliciting activities, and illicit drug trafficking and damaging BART properties or hindering BART operations. Stay away citations would be issued to violators who were found to commit three infractions.

He stated that BART has already formed a Transit Advisory Committee. The committee provides oversight, trainings and appeals for AB 716.

Mr. Sandoval is the Crisis Intervention Training trainer for BART. He is on the transit advisory committee.

Ms. Raine works for the Community Oriented Policing Unit Office of the Chief and does community outreach services. She shared with the board some of the public's concerns about AB 716.

She said that the advisory group reviews and monitors the training process. The advisory group is composed of citizens from BART's five regional areas, a person from the Disability Task Force, a union member, a BART person, an attorney and a youth services person, which is Mr. Sandoval because he has prior experience with youth.

She mentioned that there will be an annual report showing the number of stay away orders including different types, numbers, category, and the number of appeals with the reasons.

She also stated that trainings will cover mental health, homelessness, and disability issues.

Dr. David Lewis clarified that the California State legislature created AB 716 to be an optional mandate for regional transit authorities, not a mandatory requirement that must be implemented. He wondered if AB 716 were in place today, how many stay-away orders would have been issued.

BART Police Lt. Forte mentioned that in California there are two regional transit districts that have implemented AB 716 to issue prohibition orders against anyone who commits certain offenses. In the past year, Sacramento Regional Transit District had nine prohibition orders and Fresno Area Express issued 27 of them. These orders had not been appealed.

Dr. David Lewis asked if AB 716 would be enforced if the public were having protests.

BART Police Lt. Forte mentioned that AB 716 does not apply to demonstrations that have proper permits and demonstrators don't hinder BART operations.

Dr. David Lewis asked if AB 716 would be enforced if people carried protest signs.

BART Police Lt. Forte said that AB 716 does not apply in that situation as long as the sign carriers do not hinder BART operations.

Dr. David Lewis asked for more explanation about the mental health training component.

Mr. Sandoval stated that CIT incorporates mental health training sensitivity.

Mr. Lee emphasized that AB 716 profiles violent offenders. In the past several years BART agents were severely assaulted. BART has had to go to the District Attorney's office of a particular

individual county to seek stay-away orders against violators. The multi-county nature of the BART system requires a quicker and more effective way to bar violent offenders from all counties, instead of just each individual county where the crime was committed.

Dr. Patterson asked for clarification on narcotic offenses. Specifically, he wanted to know if a narcotic offense is applicable only on a BART train, BART stations or BART parking lots. He also wanted to know if a narcotic offense is for seriously offenses or just a simple impediment on transit.

Ms. Chien is with the San Francisco Public Defender's office and she wanted to know about the time table for implementing AB 716.

BART Police Lt. Forte stated that BART is seeking public concerns on AB 716 from all five counties in the Bay Area. He expects that AB 716 would be implemented in May 2013.

Ms. Chien asked if a person with mental illness were issued a stay away order but that person later on received treatment would BART rescind or vacate the order.

BART Police Lt. Forte stated that over 100 or 200 officers have received CIT trainings. BART has a goal to train all officers and dispatchers, as well. He believed that review officers should be able to intervene.

Mr. Lee said that the legislature was signed by Governor Jerry Brown in October 2011 and it became law in January 2012. BART postponed the implementation because it wants to develop training and community input first.

BART Police Chief Kenton stated that he is contemplating whether the duration of stay away orders should be 30, 60 or 90 days. The time duration is dependent on an individual need for public transit. He believes the time can be modified.

Mr. Vinh asked if there is any cooperation between BART and MUNI.

BART Police Lt. Forte stated that there has been no interaction between BART and MUNI at this time.

Dr. David Lewis congratulated BART for its thoughtfulness and outreach to the Mental Health Board and the public. He asked if a person were identified and restricted access to BART, then how would BART determine if that person trespassed.

BART Police Lt. Forte stated that transit officers may recognize the offenders.

3.2 Public comment

Ms. Terry Byrne wanted to know how the public will be informed of AB 716.

Mr. Lee said that the public should attend meetings like this one. There are additional posters in stations and on trains. He hopes to deter violent offenders with AB 716.

Ms. Kate Griffin was concerned about arrests being politically motivated. She wondered why BART has not made a full disclosure of the use of private police forces to the ACLU (American Civil Liberty Union), the National Lawyer Guild and Paratransit Committees.

She pointed out people's private information on clipper cards will be used nefariously for profiling purposes. She is very upset with AB 716 because BART is overreaching its authority.

Mr. Don Savoy worked with BART before and is currently a director of the Civic Center. He felt AB 716 is a tool for BART.

Member of the public stated that business owners are concerned about patrons getting into the City on BART. He believed that rather than help AB 716 is nothing more than a hindrance.

Member of the public pointed out he has witnessed incidents where disenfranchised people being harshly treated for asserting their rights against bullying by BART police and has observed BART police using excessive force on minorities.

Member of the public mentioned that if BART goes forward with AB 716 then some cited people in San Francisco, for example, don't have other optional transportation and must rely on BART for medical and legal appointments, grocery shopping and social services. He felt that AB 716 would help BART police at the expense of too many people who depend on BART for trips of necessity.

Member of the public mentioned that often BART police are unfamiliar with chronic neurological disorders like seizures and epilepsy and may misconstrue a BART patron's inability to obey directives and be charged with combative, uncooperative, resisting arrest and assaulting an officer. He added often BART police respond with restraint on a person with an acute seizure and would cause that person to be terminated from positional asphyxia.

Member of the public voiced that since AB 716 is optional not mandatory, then it would behoove BART not to implement it. He believed that AB 716 is just another crutch that would cripple BART's public image and just further alienate the public. He suggested that if BART's public image were to be about peace keeping rather than law enforcement then BART would reduce confrontational and adversarial situations with patrons and would earn public respect out of admiration rather than out of despotic fear!

BART Police Chief Kenton thanked the public and the board for the opportunity to present AB 716. He stated that his administration is committed to provide a transit friendly environment.

Mr. Sandoval stated that he was hired to interact with people using the BART system who have mental health issues.

BART Police Lt. Forte stated that his training staff is interested in implementing AB 716 for safety reasons. He emphasized that AB 716 is not a magic bullet but another tool for BART to respond to violent situations. He hopes that in the future BART and MUNI would collaborate on transit safety.

ITEM 4.0 ACTION ITEMS

For discussion and action

4.1. Public comment

No public comment.

4.2. PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of January 9, 2013 be approved as submitted.

There was no quorum tonight so no vote was taken.

ITEM 5.0 REPORTS

5.1 Report from the Executive Director of the Mental Health Board.

Ms. Brooke announced that the 2012-2013 Program Review schedule is in process.

5.2 Report from the Chair of the Mental Health Board and the Executive Committee.

Ms. Argüelles said that because of the need to hold a public hearing on this important issue, the Executive Committee moved the elections of new officers to the March 2013 board meeting. She announced that the nominations have changed since those announced at the January 2013 meeting. The change is Dr. David Lewis and Ellis Joseph will be running for the positions of Co-Chair, Wendy James for Vice Chair, and we still need a nomination for secretary."

The Executive committee meets Thursday, February 21st at 6:30 at 1380 Howard Street in Room 515. All board members are welcome to attend the meeting as well as members of the public.

5.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

No issues were mentioned.

5.4 Report by members of the Board on their activities on behalf of the Board.

Dr. Patterson reported that he met with Supervisor David Campos and updated the supervisor on tonight's meeting with BART on AB 716 and gang violence. He informed the supervisor about Laura's Law and Tasers. The supervisor suggested the board make more resolutions about the above issues.

Ms. Virginia Lewis reported that she recently attended a NAMI meeting. She expressed interest in learning how MHSA money has been allocated.

Ms. Robinson responded to Ms. Lewis interest in MHSA funding by suggesting she attend MHSA advisory meetings. Ms. Robinson mentioned that she expected an annual report in 30 days.

Mr. Wishom reported that he coordinated a volunteer group for Project Homeless Connect.

5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

No public comment.

5.6 Public comment.

Ms. Kate Griffin said that the members of the Paratransit Advisory Committee cannot use transit in a normal way.

Ms. Robinson suggested that board members visit Jail Psychiatric Services.

Ms. Terry Bohrer asked if there is any disaster mental health plan for San Francisco.

Ms. Robinson said that CBHS has a disaster mental health plan and has trained staff on psychiatric first aid. She said the State has a plan where all providers should have 120 trained staff, and encouraged the board to look into the disaster mental health plan.

ITEM 6.0 PUBLIC COMMENT

No public comment.

ADJOURNMENT

Meeting adjourned at 7:45 PM.



BART Police Contact

Lauren Sugayon
Office of the Chief- COPPS
Office Phone: (510) 464-7052
Email: lsugaya@bart.gov

Tyrone Forte
Police Lieutenant
Office Phone: (510) 464-7012
Email: tforte@bart.gov

Kenton Rainey
Police Chief
Office Phone: (510) 464-7022
Email: krainey@bart.gov



New Authority to Protect Riders and Employees

AB 716 BACKGROUND

The Bay Area Rapid Transit District (BART) has received an increasing number of complaints from riders and employees regarding safety on BART trains, in parking lots, stations and passenger waiting areas. In an effort to better protect its riders and employees, BART requested and received new authority to implement additional security measures to reduce passenger misconduct and disruptions. A new exclusion process is intended to enhance the quality of service and safety in the BART system.

California State Assembly Bill 716 (Dickinson) was enacted into law in 2012 and allows BART to issue "stay away" orders to people who are cited or arrested for certain offenses, thus reducing the number of crime-related disruptions.

NEW "STAY AWAY" SAFETY PROGRAM

Citizens arrested or convicted can be issued a "stay away" order for a misdemeanor or felony committed on a train or in a station or parking lot on BART property for acts of violence or threats of violence upon passengers and transit employees, lewd or lascivious behavior, or possession for sale of a controlled substance.

OR

Citizens convicted of entering or remaining on BART property without permission with the intent to interfere or hinder with the safe operation of any car or train.

OR

Citizens cited on at least three separate occasions within a period of 90 consecutive days can be issued a "stay away" order for any of the following violations:

- Willfully disturbing others by engaging in unruly behavior.
- Carrying hazardous materials in transit facility or vehicle.
- Urinating or defecating in a system facility or vehicle.
- Willfully blocking the free movement of another person.
- Defacing facilities or vehicles with graffiti or other materials.

WORKING WITH THE COMMUNITY TO IMPLEMENT

An oversight committee comprised of local residents with experience in the areas of mental health, homelessness, public safety, and cultural awareness will monitor the number of citations and exclusions issued by BART and oversee the training of transit personnel. Training of transit personnel is mandated in order to recognize and facilitate the special needs of homeless and those who may have psychiatric disabilities. Also, since this new BART security effort will exclude specific individuals, an appeals process will be established for those who believe they have been mistakenly cited or are transit-dependent.



SAN FRANCISCO MENTAL HEALTH BOARD

Mayor Edwin Lee

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, March 13, 2013
City Hall
One Carlton B. Goodlett Place
2nd Floor, Room 278
6:30 – 8:30 PM

CALL TO ORDER

ROLL CALL

AGENDA CHANGES

Item 1.0 DIRECTORS REPORT

For discussion.

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public Comment

Item 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

For discussion.

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Updates

2.2 Public Comment

Item 3.0 PRESENTATION: TRAUMA SUMMIT REPORT, LENA MILLER, MSW

For discussion

3.1 Presentation: Trauma Summit Report, Lena Miller, MSW

3.2 Public comment

Item 4.0 ACTION ITEMS

For discussion and action.

4.1 Public comment

4.2 . PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of January 9, 2013 be approved as submitted.

4.3 . PROPOSED RESOLUTION: Be it resolved that the notes for the Mental Health Board meeting of February 13, 2013 be approved as submitted.

4.4 **PROPOSED RESOLUTION (MHB 2013-1):** Be it Resolved that the Mental Health Board congratulates California Pacific Medical Center (CPMC) in reaching a tentative development agreement with the city of San Francisco but also strongly urges the city to ask CPMC to restore previously eliminated inpatient Psychiatric Beds and offer more support for community mental health services as part of Sutter Health's rebuilding of St. Luke's hospital and the new construction of their Cathedral Hill hospital.

Item 5.0 ELECTION OF OFFICERS

5.1 Public Comment

5.2 Report from Nominating Committee

The Nominating Committee stated the nominees at the November 15, 2012 meeting as: Co-Chairs: Dr. Terence Patterson and Virginia Lewis, Co-Vice Chair: Ellis Joseph and Wendy James; Secretary: Dr. David E. Lewis. Since then, Dr. Patterson and Ms. Lewis decided not to run for Co-Chairs. In their place, Mr. Joseph and Dr. Lewis offered to run for Co-Chair. Ms. James will still run for Vice Chair and Ms. Lewis has volunteered to run for Secretary. Additional nominations can be taken from the floor at this time.

5.3 Election of Officers

Item 6.0 REPORTS

For discussion and possible action.

6.1 Report from the Executive Director of the Mental Health Board.
Discussion regarding upcoming events, conferences, or activities that may be of interest to board members; Mental Health Board budget issues and update on staff work on board projects.

6.2 Report of the Chair of the Board and the Executive Committee.
Discussion regarding Chair's meetings with Community Behavioral Health Services staff, meetings with members of the Board of Supervisors and community meetings about mental health or substance abuse.

6.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

6.4 Report by members of the Board on their activities on behalf of the Board.

6.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

6.6 Public comment.

Item 7.0 PUBLIC COMMENT

ADJOURNMENT

DISABILITY ACCESS

1. Room 278 is accessible to persons using wheelchairs and others with disabilities. Assistive listening devices, materials in other alternative formats, American Sign Language interpreters and other accommodations will be made available upon request. Please contact Darlene Daevu, Community Behavioral Health Services, 415-255-3426 or by email: Darlene.daevu@sfdph.org. Providing at least 72 hours notice will help to ensure availability. To reach a TTY line, call (415) 255-3449. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at City Hall, One Dr. Carlton B. Goodlett Place (between Grove and McAllister), in Room 278. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 71 Haight/Noriega. Also, the J, K, L, M, and N lines underground. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. Special Hearings are usually held at the Department of Public Health, 101 Grove Street, 3rd Floor, Room 300. The same public transportation options as above apply. It is wheelchair accessible.

4. For Special Hearings at other locations, please call for directions or bus information. All locations will be accessible.

5. City Hall is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on One Dr. Carlton B. Goodlett Place.

6. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: sotf@sfgov.org

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from the Task Force or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: www.sfgov.org/sunshine

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: www.sfgov.org/mental_health. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

Lobbyist Registration and Reporting Requirements

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics



PROPOSED RESOLUTION (MHB 2013-XX): Be it Resolved that the Mental Health Board congratulates California Pacific Medical Center (CPMC) in reaching a tentative development agreement with the City of San Francisco but also strongly urges the City to ask CPMC to restore previously eliminated inpatient Psychiatric Beds and offer more support for community mental health services as part of Sutter Health's rebuilding of St. Luke's hospital and the new construction of their Cathedral Hill hospital.

WHEREAS, the need within San Francisco for both inpatient psychiatric hospital beds and outpatient community mental health services exceeds their current availability.

WHEREAS, the costs to the community of untreated mental illness are tragic including domestic abuse, school violence, substance abuse, homelessness, emergency room visits, suicide plus all the resulting and outward radiating trauma impacting surrounding family and friends.

WHEREAS, CPMC's non-profit tax exempt status earns it close to \$90 million annually in tax exemptions in San Francisco.

WHEREAS, non profit hospitals as part of their community benefit obligations must provide their fair share of mental health as well as medical health services.

WHEREAS, four years after acquiring St. Luke's in 2001 from the Episcopal Diocese, CPMC's parent company Sutter Health closed St. Luke's 32 bed inpatient psychiatric unit which violated a brokered agreement with the state attorney general's office and despite unanimous opposition from the San Francisco Health Commission, leaving St. Luke's without any psychiatric beds.

WHEREAS, this new development agreement does not provide for any restoration of these inpatient psychiatric beds and leaves both St. Luke's and Cathedral Hill hospital without a single psychiatric bed.

WHEREAS, San Francisco General Hospital's Psychiatric Emergency Services (PES) unit is often crowded beyond capacity and consequently forced to turn away patients.

THEREFORE, BE IT RESOLVED that the Mental Health Board of San Francisco urges the Board of Supervisors and the Mayor to ask Sutter Health and CPMC to restore a minimum of 38 inpatient psychiatric beds at either St. Luke's and/or their new Cathedral Hill hospital plus provide funding for follow up community residential care and also provide more support for community mental health programs all of which can help reduce the need for inpatient treatment.



SAN FRANCISCO MENTAL HEALTH BOARD

Edwin Lee
Mayor

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Unadopted Notes

Mental Health Board

Wednesday, March 13, 2013

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

San Francisco, CA

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BOARD MEMBERS PRESENT: M. Lara Siazon Argüelles, Chair; Ellis Joseph, MBA, Vice Chair; David Elliott Lewis, Ph D, Secretary; Sgt. Kelly Dunn; Kara Chien, JD; Virginia S. Lewis, LCSW, MA; Lena Miller, MSW; and Terence Patterson, EdD, ABPP.

BOARD MEMBERS ON LEAVE: Wendy James; Alyssa Landy, MA; Alphonse Vinh and Errol Wishom.

BOARD MEMBERS ABSENT: Lynn Fuller, JD.

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jo Robinson, Director of Community Behavioral Health Services (CBHS); LaVaughn Kellum King; Jo Elias Jackson; Dale Milfay; Crystal Marsonia, Westside Cal-Works Counseling Services; San Francisco Sheriff Ross Mirkarimi; Mahanadi Clay; Vivian Impernale; Brenda Barros, SEIU 1021; Teresa Luokuot; Pastor Daniel Solberg, St. Paulus Lutheran Church; Domingo McFaul; Minister Andreus Pielhoop; Brian Tseng, POC (Physician Organizing Committee) Operations Manager; Geoffrey Wilson, MD, President of POC; Brenda Barros; Scott Weaver; Dale Milfay, Andrea Feloe and six members of the public.

CALL TO ORDER

Ms. Argüelles called the meeting of the Mental Health Board to order at 6:42 PM.

ROLL CALL

Ms. Brooke called the roll. Quorum was not attained.

AGENDA CHANGES

There were no changes to the agenda.

ITEM 1.0 DIRECTOR'S REPORT

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

Please see the attached March 2013 Director's report.

Ms. Robinson highlighted the following items included in the March Director's report.

She said that the Triple P – Positive Parenting Program has evolved over the past 35 years. On February 20, 2013 David Bornstein from the New York Times wrote the Benefits of Positive Parenting (<http://opinionator.blogs.nytimes.com/2013/02/20/helping-the-parents-to-spare-the-children/>).

The smoking rate between adults with mental illness and adults without mental illness is 70% higher. Smokers with mental illness smoke more cigarettes (331 vs. 310 cigarettes per month) than smokers without mental illness. Both groups have the same desire and ability to quit smoking.

She announced that since September 2012, Chinatown North Beach Mental Health (CTNB) clinic has provided services in smoking reduction/cessation. By incorporating mindfulness exercises with peer support and education, the clinic has seen positive results.

She stated that as a result of the Katie A statewide lawsuit, Children Youth and Families (CYF), Human Services Agency (HSA) and child welfare did a two day inter-departmental planning summit on March 4th and March 5th, 2013.

She said that, unfortunately, the public at large still has a much distorted view of mental illness. Such a distortion has further stigmatized, and marginalized people with mental illness, including persecution and disenfranchisement. It is fallacious to believe that people with mental illness commit more violent crimes than people without mental illness do. In fact, more often than not people with mental illness are easy targets for victimization and exploitation. She hoped that the new modified Associated Press Stylebook, which is often used by journalists and people in the media will increase public awareness on mental illness.

She talked about dialectical behavior therapy (DBT) which was founded in the early 1990's by Dr. Marsha M. Linehan. Although DBT originally addressed symptoms of borderline personality disorder, recently, DBT has been effective in treating patients who present varied symptoms and behaviors associated with spectrum mood disorders including schizophrenia. Recent works suggests DBT effectiveness in helping sexual abuse survivors and clients/patients with chemical dependency.

The independent External Quality Review Organization (EQRO) conducted a three-day review last month. In about three months, she expects the report on the review which she believes will be positive.

On May 15, 2013, Richmond Area Multi-Services (RAMS) instead Community Vocational Enterprises (CVE) will be funded by CBHS to provide vocational training for people with mental illness. Since 2011, CVE has been on a corrective action plan due to its financial decline. But, we expect them to re-contract with CBHS in about 18 months after the program reaches sustainable financial stability.

Dr. David E. Lewis inquired as to how San Francisco ranked among other California counties and Medi-Cal eligibility, which is Medicaid in California, during the EQRO review.

Ms. Robinson stated that the EQRO brought and shared lots of comparative data. But the State of California only reports on San Francisco Medi-Cal population. Comparing to other California counties, San Francisco has a higher 30-day hospital readmission rate as San Francisco has spent more money on diagnosing psychoses. The final report from the EQRQ will be available on the public website.

Mr. Joseph commented that the \$2,000 Medi-Cal ceiling has resulted in people revolving in-and-out of Medi-Cal eligibility and services.

Ms. Robinson stated that the new Obama Care in 2014 should provide a bridge extending Medi-Cal eligibility up to the 138% FPL rather than the current 133% FPL.

Monthly Director's Report **March 2013**

1. ASPE Research Brief Estimates ACA will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans

The U.S. Department of Health and Human Services (HHS) has issued through its Office of the Assistant Secretary for Planning and Evaluation (ASPE) an ASPE Research Brief, "*Affordable Care Act Will Expand Mental Health and Substance Use Disorder Benefits and Parity Protections for 62 Million Americans*," explaining how the ACA "will provide one of the largest expansions of mental health and substance use disorder coverage in a generation." The report notes that – overall – some 62.5 million Americans will "benefit from federal parity protections as a result of the ACA." These Americans include 11 million who are currently in individual plans, 24.5 million now in small-group plans, and 27 million who are currently uninsured, all of whom will be required under the EHB final rule to have mental health and substance use disorder coverage as one of 10 required benefit categories.

2. New York Times Does a Story about Triple P

In February, Stephanie Romney, PhD, Director of The Parent Training Institute, was interviewed by David Bornstein, a reporter with the New York Times, about Triple P. The story came out in the 2/20/13 paper and it does a nice job of highlighting both the science behind the intervention and the positive impact that it has on families. Here is the link:
<http://opinionator.blogs.nytimes.com/2013/02/20/helping-the-parents-to-spare-the-children/>

3. Mental Health Association of San Francisco and San Francisco's Suicide Prevention to Begin Suicide Attempt Survivor's WRAP Support Group

MHASF and San Francisco Suicide Prevention are proud to announce the first Suicide Attempt Survivor's WRAP Support Group, which will begin in April. For more information contact:

Mental Health Association of San Francisco
Contact: Jennifer Awa
Phone Number: 415-341-9507

4. Kidney Failure Related to Synthetic Marijuana

16 cases of kidney failure related to synthetic marijuana have been reported by poison control and emergency rooms from Kansas, Oklahoma, Oregon, New York, Rhode Island and Wyoming. Products similar to marijuana, called 'cannabinoids' are sometimes sold online, so they could cause problems in any state. Some names for these products are K2, spice, lava, flame, Mr. Happy, clown loyal, etc. Young people sometimes use these substances, thinking they are safer than marijuana and 'legal'. The ages of the persons who developed kidney failure ranged from 15 to 33, and some of them needed dialysis. If you serve an adolescent and young adult population, you may want to post an alert in your office.

5. Sacramento Bee Writes about San Francisco's Library Social Worker Program

<http://www.sacbee.com/2013/02/17/5196254/san-francisco-library-offers-refuge.html>

6. Treatment Episode Data Set - Discharges aged 12 and Older from Substance Abuse Treatment Programs

This report presents results from the Treatment Episode Data Set (TEDS) for **discharges aged 12 and older from substance abuse treatment in 2009**. The report provides information on treatment completion, length of stay in treatment, and demographic and substance abuse characteristics of discharges from alcohol or drug treatment in facilities that reported to individual State administrative data systems. Some highlights of the report:

Discharges by Type of SA Service

Of the 1,620,588 discharges aged 12 and older in 2009:

- 42 percent were discharged from outpatient treatment
- 20 percent were discharged from detoxification
- 12 percent were discharged from intensive outpatient treatment
- 11 percent were discharged from short-term residential treatment
- 8 percent were discharged from long-term residential treatment
- 6 percent were discharged from medication-assisted (i.e., using methadone or buprenorphine)
 - o opioid therapy or detoxification
- Less than 1 percent were discharged from hospital residential treatment

Reasons for Discharge

Of the 1,620,588 discharges aged 12 and older in 2009:

- 47 percent of the discharges completed treatment
- 14 percent of the discharges were transferred to further treatment
- 25 percent of the discharges dropped out of treatment
- 7 percent of the discharges had treatment terminated by the facility
- 2 percent of the discharges were incarcerated
- 6 percent of the discharges failed to complete treatment for other reasons

**Percentages do not sum to 100 percent because of rounding.*

Treatment Completion by Service Type

The treatment completion rate was 47 percent for discharges aged 12 and older from all service types

combined. For individual service types, treatment was completed by:

- 66 percent of discharges from detoxification
- 59 percent of discharges from hospital residential treatment
- 52 percent of discharges from short-term residential treatment
- 49 percent of discharges from medication-assisted opioid detoxification
- 46 percent of discharges from long-term residential treatment
- 42 percent of discharges from outpatient treatment
- 35 percent of discharges from intensive outpatient treatment
- 14 percent of discharges from outpatient medication-assisted opioid therapy

Median Length of Stay (LOS)

The median LOS in treatment by type of service was:

- 161 days for discharges from outpatient medication-assisted opioid therapy
- 92 days for discharges from outpatient treatment
- 60 days for discharges from intensive outpatient treatment
- 59 days for discharges from long-term residential treatment
- 22 days for discharges from short-term residential treatment
- 13 days for discharges from hospital residential treatment
- 6 days for discharges from medication-assisted opioid detoxification
- 4 days for discharges from detoxification

The median LOS by type of service, limited to only those who completed treatment, was:

- 197 days for discharges completing outpatient medication-assisted opioid therapy
- 124 days for discharges completing outpatient treatment
- 90 days for discharges completing long-term residential treatment
- 85 days for discharges completing intensive outpatient treatment
- 27 days for discharges completing short-term residential treatment
- 19 days for discharges completing hospital residential treatment
- 5 days for discharges completing medication-assisted opioid detoxification
- 4 days for discharges completing detoxification

For the full report, please go to: <http://www.samhsa.gov/data/2k12/TEDS2009N/TEDS09DWeb.pdf>

7. Smoking among U.S. adults with mental illness 70 percent higher than for adults with no mental illness – assessment and intervention is important

Studies show need for enhanced prevention and quitting efforts for people with mental illness.

Adults with some form of mental illness have a smoking rate 70 percent higher than adults with no mental illness, according to a Vital Signs report released today by the Centers for Disease Control and Prevention in collaboration with the Substance Abuse and Mental Health Services

Administration (SAMHSA). The report finds that 36 percent of adults with a mental illness are cigarette smokers, compared with only 21 percent of adults who do not have a mental illness.

According to the report, nearly 1 in 5 adults in the United States – about 45.7 million Americans—have some type of mental illness. Among adults with mental illness, smoking prevalence is especially high among younger adults, American Indians and Alaska Natives, those living below the poverty line, and those with lower levels of education. Differences also exist across states, with prevalence ranging from 18.2 percent in Utah to 48.7 percent in West Virginia.

Combined data from SAMHSA's 2009–2011 National Survey on Drug Use and Health (NSDUH) were used to calculate national and state estimates of cigarette smoking among adults aged 18 years and older who reported having any mental illness. Mental illness was defined as having a diagnosable mental, behavioral, or emotional disorder, excluding developmental and substance use disorders, in the past 12 months.

"Smokers with mental illness, like other smokers, want to quit and can quit," said CDC Director Tom Frieden, M.D., M.P.H. "Stop-smoking treatments work-and it's important to make them more available to all people who want to quit."

The report confirms that on average adult smokers with mental illness smoke more cigarettes per month than those without mental illness (331 vs. 310 cigarettes). Adult smokers with mental illness are also less likely to quit smoking cigarettes than adult smokers without mental illness. "Special efforts are needed to raise awareness about the burden of smoking among people with mental illness and to monitor progress in addressing this disparity," said SAMHSA Administrator Pamela S. Hyde.

To address the high rates of tobacco use among persons with mental illness, SAMHSA, in partnership with the Smoking Cessation Leadership Center (SCLC), has developed a portfolio of activities designed to promote tobacco cessation efforts in behavioral health care. SAMHSA and the SCLC developed and implemented the 100 Pioneers for Smoking Cessation Campaign, which provide support for mental health facilities and organizations to undertake tobacco cessation efforts.

SAMHSA and the SCLC expanded the Pioneers Campaign by working with states through Leadership Academies for Wellness and Smoking Cessation, whose goal is to reduce tobacco use among those with behavioral health needs and staff. Participating states bring together policymakers and stakeholders (including leaders in tobacco control, mental health, substance abuse, public health, and consumers) to develop a collaborative action plan.

CDC also works closely with national partners, state tobacco control programs, and other stakeholders to address smoking among individuals with mental illness. For example, the Break Free Alliance, a CDC grantee, is working with national partners to address tobacco use in this population.

8. Smoking Reduction/Cessation Groups at Chinatown North Beach

Since September 2012, Chinatown North Beach (CTNB) Mental Health Clinic has been offering smoking reduction/cessation groups with a mindfulness component, in English and Chinese

(Cantonese). The goals of these groups are to promote smoking reduction/cessation and wellness by providing education, anti-smoking therapeutic aides (including introduction to mindfulness), and peer support.

Facilitating these groups are Kim So-Che PharmD, bilingual clinical pharmacist, Serina Deen MD, UCSF Public Psychiatric Fellow, and Wan Fen (Angel) Liu, MHSA-funded bilingual public service aide. The clinical pharmacist provides smoking cessation education, oversees nicotine replacement therapy, and facilitates the group discussions. For the English sessions, Dr. Deen introduces mindfulness exercises that are adapted works from Drs. Judson Brewer and Jon Kabat-Zinn. The public service aide translated these exercises and leads the mindfulness component for the Chinese sessions. Due to positive client interest in continuing mindfulness at home, we are in the process of recording audio CDs in English and Cantonese for client's home use.

To date, CTNB has facilitated one English-speaking and one Chinese-speaking group. These groups consisted of 6-8 weekly meetings with monthly follow-up based on participant interest. There are plans for more English and Chinese groups throughout the year.

9. Children, Youth and Families

On March 4th and 5th, Children, Youth and Families co-hosted a two day interdepartmental planning summit for implementation of the Katie A. statewide lawsuit.

The original complaint was filed in July of 2002 to obtain wraparound and therapeutic foster care services for children in or at risk of placement in foster care or group homes. The final settlement was approved in December of 2011.

Class Members: The settlement identifies a class of children who must be provided better services through what is being called the Core Practice Model or CPM. In addition, a smaller subset within this larger class must also be provided with a set of intensive services in addition to the CPM.

1. The main class of children and youth whose needs are to be addressed through the reforms mandated by the settlement are those who are:
 - a. In foster care or at imminent risk of placement. For purposes of this case, "imminent risk of foster care placement" means that within the last 180 days a child has been participating in voluntary family maintenance services or voluntary family reunification placements, and/or been the subject of either a telephone call to a Child Protective Services hotline or some other documentation regarding suspicions of abuse, neglect, or abandonment in foster care; and,
 - b. Have a mental illness or condition that has been documented, or, if an assessment had been conducted would be diagnosed with a documented mental illness or condition; and,
 - c. Who need individualized mental health services, including but not limited to professionally acceptable assessments, behavioral support and case management services, family support, crisis support, therapeutic foster care, and other medically necessary

services in the home or in the home-like setting, to treat or ameliorate their illness or condition.

2. The subclass of the main class includes those children and youth who are experiencing a need for intensive services, are full-scope Medi-Cal eligible, meet medical necessity, have an open child welfare services case, and meet either of the following criteria:
 - a. Are currently in or being considered for wraparound, treatment foster care, or a specialized care rate due to their behavioral health needs; or,
 - b. Are currently in or being considered for placement in an RCL 10 or above group home, psychiatric hospital, or 24 mental health facility, or have experienced 3 or more placements within 24 months due to behavioral health needs.

The Summit focused on developing a implementation vision for San Francisco. Representatives from HSA, Education, Probation, CBHS, Family Partners and CBO's currently providing intensive services brainstormed ideas, evaluated our current system and sketched initial concepts for system enhancements. A small work group collected the data at the end of day 2 and organized it into a work plan and process map moving forward. The meeting was a great example of inter-departmental collaboration.

The Trauma-Informed initiative is moving forward. A core group has begun to sketch out a principles, practices and implementation plan for developing and delivering the curriculum across Community Programs and CBO's. The current timeline is to complete a draft curriculum by the end of June. July and August 2013 will be spent vetting the curriculum with all the key stakeholders including local trauma experts across the developmental continuum, administration, line staff, CBO's and people with lived experience. In September of 2013 the goal is to pilot a training in order to work out glitches and make modifications. The goal is to begin rolling the training out in January 2014 by having some large trainings and train the trainer modules.

10. Marsha Linehan, developer of DBT, tells her story of her own struggles with borderline personality disorder – A powerful illustration of recovery

http://www.nytimes.com/2011/06/23/health/23lives.html?pagewanted=1&_r=0&ref=health

11. Veteran's Program in San Francisco County Jail

The San Francisco Sheriff's Department's COVER Program (Community of Veterans Engaged in Restoration) is designed to serve the increased number of justice-involved veterans who are incarcerated in the San Francisco County Jails. San Francisco County is one of the first jail systems nationally to respond to the call for "comprehensive, integrated treatment...in a single venue" for the veteran population. Clients who meet the criteria for participation in the COVER Project are identified upon arrest by the San Francisco Sheriff's Department. The inmates are subsequently transported to the COVER Project at County Jail 5 in San Bruno.

The therapeutic core of the COVER Program is composed of daily groups tailored to address the specific psychological needs of the veteran population. The program's therapeutic groups are

grounded in evidence-based-practices that include Motivational Interviewing, Seeking Safety, Cognitive Behavioral Therapy, and Thinking for a Change. Additionally, the veterans attend non-violence communication and conflict resolution groups as well as parenting and relapse-prevention classes. Clients also receive individual weekly face-to-face therapy and psychiatric medication management as indicated.

The COVER project collaborates and works closely with other interdepartmental and community agencies that include, Jail Psychiatric Services, the Veteran's Administration, San Francisco Swords to Plowshares, the San Francisco Sheriff's Department, Community Works, San Francisco's Community Behavioral Health Services, and Asian American Recovery Services.

12. California Mental Health Services Authority Reports that the Associated Press will Include Guidelines for Reporting on Mental Illness

CalMHSA's collective effort to change public attitudes around mental illness took a giant step forward today: The Associated Press, an international news organization, will include guidelines for reporting on mental illness in its influential AP Stylebook. Known as the "The Journalists' Bible" for its influence on the media industry, the publication is widely used by print, broadcast and online newsrooms and taught in journalism classes, so the new guidelines present an opportunity to significantly improve the way the news industry reports on mental illness.

The new entry in *The Associated Press Stylebook* directs news media to avoid describing people as mentally ill unless someone's mental health is clearly pertinent to a story and the person's diagnosis is properly sourced. The new entry addresses the assumption that mental illness is a factor in violent crime and identifies that people with mental illness are more likely to be victims of crime rather than perpetrators. It also suggests a more precise use of language, such as avoiding derogatory terms in health and non-health stories.

As you know, the news media's impact on public attitudes is profound, and ensuring that media portrayals of mental illness and individuals living with mental challenges are accurate and balanced is an important part of the Prop 63 (MHSA) supported efforts the California Mental Health Services Authority (CalMHSA) is making on behalf of counties to reduce stigma and discrimination that prevents people with mental illness from seeking services. The new guidelines for the AP were developed with our partner, the Entertainment Industries Council, as part of CalMHSA's Stigma and Discrimination Reduction Prevention and Early Intervention Initiative.

An EIC analysis of stories published in more than 20 English- and Spanish-language newspapers in California over 12 months revealed that most coverage about people with mental illness is negative and much of it links mental illness with dangerousness. The analysis, coupled with EIC's survey of 40 California reporters, shows that members of the news profession could benefit from specific guidelines and more resources to help with their coverage of mental health. In response, EIC, through the TEAM Up project, is developing a wealth of resources in English and Spanish for reporters that will supplement AP's mental health guidance. To download the materials, visit www.eiconline.org/calmhsa.

Press releases from the National Association of Broadcasters and AP can be found at

<http://www.nab.org/documents/newsRoom/pressRelease.asp?id=2886> and
<http://www.ap.org/Content/Press-Release/2013/Entry-on-mental-illness-is-added-to-AP-Stylebook>

13. Richmond Area Multi-Services, Inc. Recruiting for i-Ability: Vocational IT, Helpdesk Training Program

RAMS Hire-Ability is pleased to announce the orientation & recruitment for the i-Ability: Vocational IT, Helpdesk Training program (Cohort 4). This new 9 month cohort will begin **May 13, 2013** and end **February 2014**. They will be holding two orientation sessions this month for prospective client applicants as well as interested service providers. It is strongly encouraged that applicants attend one of the orientation sessions. The orientations will be held on Thursday March 14th at 10:00 AM and Friday March 15 at 3:00 PM. As space is limited, please call (415) 282-9675 to RSVP. Please refer to the attached flyer for eligibility and further information about the program. Please share this information with any of your clients that might be interested in this program.

14. Opening of the Re-Entry Pod at the San Francisco County Jail #2

Sheriff Mirkarimi and Probation Officer Chief Wendy Still announced the opening of the Reentry Pod, located at County Jail #2. The Reentry Pod is a collaborative effort which joins pre and post release programs for offenders to improve public safety, reduce recidivism and provide the necessary continuum of resources for a successful reentry into our communities and the tools to complete community supervision productively.

For months before Public Safety Realignment (AB109) took effect on October 1, 2011, the Adult Probation Department, Sheriff's Department, Court, Community Behavioral Health Services, and other City partners worked together diligently to safely and successfully implement this truly historic reform that shifted responsibility for many lower-level felony offenders from state to county jurisdiction. San Francisco rapidly and effectively implemented a comprehensive local strategy for implementing these far reaching and unprecedented reforms, which included in-depth community and client input. The Reentry Pod is a key component of San Francisco's Realignment implementation strategy.

The populations to be served by the Reentry Pod are individuals who will be released to the AB109 supervision of the Adult Probation Department upon completion of their custody sentence. These individuals include state prisoners who will be transferred to the Reentry Pod for the remaining months of their prison time before being released to the supervision of the Adult Probation Department under post release community supervision (PRCS), as well as individuals who are sentenced locally to jail and mandatory supervision under what is known as a split sentence (1170 (h) (5) (B) p.c.).

Community Behavioral Health Services will be providing important transitional care services to those individuals housed in the Re-Entry Pod, through the provision of bridge case management, authorization and placement into health care services, and ongoing care coordination. These services will be provided through the Behavioral Health Access

Center (BHAC), located at 1380 Howard St., 1st Floor. For additional information, contact Craig Murdock at (415) 503-4732.

15. City College of San Francisco: Community Mental Health Certificate Program

The MHSA-funded Community Mental Health Certificate Program at City College of San Francisco has been approached by the Bay Area Community College Consortium (BACCC) to either replicate or expand its work so that other community colleges in the region will be able to deliver this exemplary workforce development program and grow the mental health workforce in their own areas. On May 22, 2013 the BACCC will convene a meeting of regional community colleges, county workforce development representatives and industry stakeholders (e.g. county hospitals, nonprofit hospitals and HMO administrators, community based organizations) to continue the dialogue of mental health workforce development and role that community colleges play. Dr. Sal Nunez, Director of the Community Mental Health Certificate Program, and two of his students will speak to the group about their program and the realized benefits from the program.

16. Community Defined Evidence and Indigenous Wellness Research Institute

On March 21, 2013, the staff from DPH's Office of Quality Management (OQM), Children Youth & Families System of Care (CYF SOC), Adult/Older Adult System of Care (A/OA SOC) and Population Health & Prevention (PHP) will have a rich Learning Session with Dr. Ken Martinez from the Technical Assistance Partnership for Child and Family Mental Health and Dr. Bonnie Duran from the University of Washington's Indigenous Wellness Research Institute. Dr. Martinez will speak about the field of Community Defined Evidence as it relates to Evidence Based Practices; and Dr. Duran will discuss her work at the Indigenous Wellness Research Institute and its implications for public health.

17. CBHS completed our annual External Quality Review Organization (EQRO) Site Visit

CBHS completed our annual External Quality Review Organization (EQRO) site visit on March 5 - 7, 2013. The Department of Health Care Services (DHCS) contracts with APS Healthcare to conduct annual independent reviews of each county's quality improvement, performance management, and IT systems, with a special focus on the role of consumers and providers in working with CBHS central administration to improve the quality of care.

The EQRO review was extensive and involved numerous staff presentations, site visits, consumer/family member focus groups, and staff group interviews. We want to extend our sincere thanks to all of the staff and consumers who participated in this important review.

The review included the following site visits and focus groups:

- A site visit at the Gender Services Program at 755 S. Van Ness Ave, and a focus group with transgender consumers and family members who participate in the Transgender Support Group at 1380 Howard St.

- A site visit at DORE Clinic (Progress Foundation) and a focus group with consumers who had recently experienced psychiatric hospitalization or crisis services.
- A site visit at South of Market Mental Health Services, Integrated Services Program, and a focus group with consumers who are receiving primary care services at South of Market Mental Health through a SAMHSA Primary Behavioral Health Care Integration grant.

Staff Interviews included 10 Adult System of Care clinical line staff, 10 Children, Youth, and Families clinical line staff, 8 Civil Service Clinical Program Managers, 8 Contract Provider Managers and Administrators, central Fiscal and Billing staff, and key Information System Managers.

Staff presentations included the Wellness and Recovery Model, Performance Management Data Dashboards, Timeliness of Care, Functional Outcomes, Disparities, Transitions in Care, Primary Care and Behavioral Health Integration, Telepsychiatry, Consumer Employment, and Performance Improvement Projects.

APS Healthcare staff will produce a final report by the beginning of June that will provide important feedback to the county, with recommendations on how we can improve our work. This report is also sent to DHCS and CMS (the federal Center for Medicaid and Medicare Services). Past EQRO review reports for all California counties can be found at www.caeqro.com.

*Past issues of the CBHS Monthly Director's Report are available at:
<http://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSDirRpts.asp>
 To receive this Monthly Report via e-mail, please e-mail reanna.albert@sfdph.org*

1.2 Public Comment

Ms. Cross requested to include SROs and homeless shelters in CBHS smoking cessation/reduction programs.

Ms. Robinson stated that DPH has no jurisdiction over SRO's and homeless shelters and recommended Ms. Cross bring the smoking cessation/reduction issue to the Human Services Agency (HSA) and the Board of Supervisors.

Ms. Impernale was a former director of CVE and commented that several CVE clients were successfully transitioned into positions of staff and some clients went on to become case managers.

Ms. Robinson mentioned that the RAMS director is committed to continuing employing former CVE clients during the transitional period.

ITEM 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The

Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Updates

Ms. Robinson announced that her staff has almost completed the 2012 annual report and the report will be available soon.

The Bay Area Community College Consortium (BACCC) would like to replicate the Community Mental Health Certification Program that was offered at City College of San Francisco at other community colleges.

We are providing collaborative trainings with California Institute of Integral Studies (CIIS) to engage the indigenous population in wellness.

2.2 Public comment

Ms. Milfay asked for clarification on intensive programs for people too ill to help themselves.

Ms. Robinson stated that programs providing full service partnerships (FSP) do outreach to people with severely incapacitating mental illness.

Ms. Milfay asked if MHSA funding is adequate enough for people too ill to obtain services.

Ms. Robinson stated that the FSP funding for clients is available only when clients meet the required levels of medical necessity.

ITEM 3.0 PRESENTATION: TRAUMA SUMMIT REPORT, LENA MILLER, MSW

3.1 Presentation: Trauma Summit Report, Lena Miller, MSW

Trauma Summit Report is attached to the end of the minutes

Ms. Argüelles introduced Lena Miller, who has one of the Mental Health Professional seats on the Mental Health Board. She co-produced the Trauma Summit in November 2012.

Ms. Miller stated that over 60 people came to the summit. There were representatives from different communities, the San Francisco Department of Public Health to the peace keeping agencies.

She said that Ken Epstein and Jo Robinson have been providing statistics about PTSD. These statistics are necessary to provide a comprehensive picture to help us transform services for families and communities affected by community violence.

Ken Epstein focuses on the pervasiveness of community trauma and the prevalence of PTSD in District 10, which is part of the Southeast sector of San Francisco. PTSD has manifested largely through depression and anxiety.

The psychological pain of community violence affects everybody from infants to the elderly. In response to under resourced mental health services and wellness care programs, District 10 people have been self medicating their psychological pain through whatever substances they could find.

She pointed out that in general over 60% of the people who are actively receiving sustainable wellness and recovery services do become better and healthier. Comparing to the national average,

treatment does help individuals and families get better. She believes that more mental health services for District 10 are needed and District 10 clients would benefit from treatment just as much as the national average.

She added that since District 10 is predominantly African descent Americans, culturally appropriate treatment are beneficial. For example, mindfulness is more effective than just talk therapy alone. The others are programs and services that address trauma from historical and inter-generational perspectives.

Dr. Patterson stated that the report was excellent and added that trauma is often accompanied by co-occurring diagnoses such as anxiety, depression and acting out which are symptoms preceding PTSD. He would like to see psycho-education be part of the trauma recovery process. Clients need home-based wellness and community outreach services. He would like the board to advocate for an increase of services in District 10 and Western Addition neighborhoods.

Dr. Lewis congratulated Ms. Miller for her report that is both in-depth and broad in breadth. He asked if mindfulness is incorporated in recovery.

Ms Miller stated that during the trauma summit most attendees recognized mindfulness as both standard and necessary therapy in diffusing many anxieties. She said that she personally combines both yoga and mindfulness in her own self monitoring. Now mindfulness has become the therapeutic norm. Mindfulness is well appreciated as a way to teach people to get in touch with their bodies and working on self healing.

Dr. Lewis asked what top priorities are that the City can do for District 10.

Ms Miller said that unresolved traumatic events just perpetuate further community violence, and she would like to see more social services including trauma trainings be deployed soon.

Dr. Patterson asked about what District 10 would like to see happen first.

Ms Miller responded by saying that too many witnesses have vicarious trauma from homicides. These people, although received initial crisis care from CRN (Crisis Response Network), they are not receiving follow up care afterward. For example, kids are not getting follow up mental health care or after school trauma care enough. The other is the city leaders need to recognize more retaliatory incidents that have torn families apart.

Ms. Robinson pointed out the City's Crisis Response Team (CRT) does follow up and planned to introduce Ms. Miller to Ms. Stephanie Felder who is the director of CRT.

Ms. Chien commended Ms. Miller for the impressive report and asked how churches and community centers in District 10 have mobilized and responded to community violence.

Ms Miller replied that community violence is so severe that all interventions have been deployed. Different groups have different capacities and resources, and the DPH has responded. She felt more pro-active participation would help a lot also.

Ms. Argüelles announced that Sheriff Ross Mirkarimi just joined the meeting tonight and invited the sheriff to talk.

Sheriff Mirkarimi said that the county jail is disproportionately made up of African descent Americans. Now the jail sites are predominately made up of inmates with untreated mental illness. He stated the jail system is becoming the default place for people with mental illness. For example, elderly, homeless people and Iraq and Afghanistan veterans are being incarcerated. In jails, inmates

are triaged and 70,000 units of services were provided in 2012 by Jail Psychiatric Service. He felt the jail at best is just providing temporary palliative care. He encouraged the Mental Health Board to look at the issue of large numbers of mentally ill people in the jail system.

3.2 Public comment

Ms. King was a former board member and is currently employed by CBHS. She said that spirituality is important to wellness and recovery. She is currently facilitating RSSE (Reducing Stigma in the Southeast Sector). She said that so many District 10 residents have talked about seeing violence in front of the Boys and Girls Club in Visitacion Valley. She added that children are seeing other kids being riddled with bullets.

She was at the November 2012 Trauma Summit. She feels there is a need to get people who live in the community trained in recovery services. She believes the WRAP (Wellness Recovery Action Plan) would be helpful. She hopes more funding will be available soon.

Ms. Jackson works at the San Francisco General Hospital (SFGH) and lives in District 10. She would like to see more programs in schools, more surveys from the community to learn about needs, more outreach, and residents being treated with value.

Ms. Impernale said she served on a two-month jury for a District 10 defendant. She learned that there is a fear in the community to speak up against perpetrators because the community is afraid of retaliation to their families and other relatives. District 10 witnesses are too intimidated to speak up against those who commit homicide. There is a need for more general services.

Mr. Weaver stated that he has suffered from bi-polar disorder. He has been at OMI Clinic since 2007. He believes OMI has helped him to become functional. He believes that District 10 alone is not only being affected by mental illness. There are other people in the community who suffer just as much. He recommended the book called the Color of Water by Ruth McBride Jordan.

ITEM 4.0 ACTION ITEMS

For discussion and action

4.1. Public comment

Ms. Argüelles said that the quorum has still not been reached so no votes will be taken tonight on any action items. However, Brian Tseng, Operations Manager and Geoffrey Wilson, MD both from the Physicians Organizing Committee (POC) will provide a brief overview of the issue regarding Sutter Hospital for both the benefit of the board members and the public. The resolution will be voted on at the next board meeting.

4.2. PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of January 9, 2013 be approved as submitted.

Tabled until April Board meeting due to not meeting quorum

4.2. PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of February 13, 2013 be approved as submitted.

Tabled until April Board meeting due to not meeting quorum

4.4 PROPOSED RESOLUTION (MHB 2013-XX): Be it Resolved that the Mental Health Board congratulates California Pacific Medical Center (CPMC) in reaching a tentative development agreement with the city of San Francisco but also strongly urges the city to ask CPMC to restore previously eliminated inpatient Psychiatric Beds and offer more support for community mental health services as part of Sutter Health's rebuilding of St. Luke's hospital and the new construction of their Cathedral Hill hospital.

Dr. Geoffrey Wilson has been at SFGH Jail Psychiatric Services' inpatient unit, which is part of Psychiatric Emergency Services unit, for 35 years. He stated that he was only speaking on behalf of the Northern California for Physicians Organizing Committee (POC).

He described briefly that Sutter Health is the parent company of California Pacific Medical Center (CPMC). After Sutter Health acquired St Luke's Hospital in 2001, CPMC closed down 32 psychiatric beds in 2004 over the objection of the San Francisco Health Commission.

Now Sutter Health/CPMC is in the process of building its fifth hospital called Cathedral Hill Hospital and remodeling St Luke's Hospital in San Francisco. These two hospitals would add 630 beds, but there are no psychiatric crisis beds allocated because Sutter believes that psychiatric services are not profitable.

He agreed with Sheriff Mirkarimi that San Francisco county jails are becoming the holding place for people with mental illness because there is a growing mentally ill population in San Francisco especially among the elderly, homeless people and Iraq and Afghanistan veterans.

The increasing demand for services for people with mental illness is very strong in San Francisco. Medi-Cal uses extreme criteria for accepting patients with acute psychosis. He urged the board to approve the proposal. People with mental illness are disenfranchised, and he believes that people with mental illness are entitled to psychiatric care but services for them are being denied because of their psychiatric disability.

Public Comment

Ms. Barros has worked at Laguna Honda Hospital for 30 years and represents nurses and certified nurse aides (CNA's) said that she is a strong proponent of peer support. But she believed that both extensive psychiatric care and more psychiatric beds are necessary.

Ms. Jackson stated emphatically that 38 psychiatric beds are not enough for the growing population of San Francisco!

Ms. Milfay favored the resolution because of the loss of over 100 acute psychiatric beds, and because of decreasing day treatment programs. She pointed out that in 1996 St Francis Hospital had 50 voluntary and involuntary psychiatric beds, but currently the hospital only has 25 involuntary beds.

There is a shortage of psychiatric beds in San Francisco. She said Langley Porter which is operated by UCSF is currently under remodeling. In 2004, psychiatric beds at St Luke's Hospital were shut down. The current 15 psychiatric beds at CPMC are dilapidated. The bed shortage is reaching a critical point.

She mentioned that her son was turned away for a psychiatric bed because he was perceived as not being sick enough. She believes people with acute mental illness need all levels of services.

Ms. Luokuot, with SEIU 1021 asked “Why aren’t we [San Franciscans and the BOS] trying to get Sutter Health/CPMC to abide by its contractual obligation to reinstate psychiatric beds?”

Mr. Tseng stated that Sutter Health/CPMC substitution of inpatient care with community programs is inappropriate in an urban setting like San Francisco.

Mr. Weaver stated that San Francisco should require other hospitals like UCSF, Kaiser Foundation, and Dignity Health to have psychiatric beds as well.

Mr. Silver said that San Francisco Cares has a mixed clientele in desperate need for services. He has talked to San Francisco supervisors, but they seemed to be unaware and underappreciated the risk of the psychiatric bed shortage.

Mr. Feloe, with the San Francisco Night Ministry stated that the true need for mental health services is actually much higher than what is reported in the press.

Ms. Luokuot mentioned that her son is now in jail for three years because he was arrested for illicit drugs.

Dr. Wilson stated that he spoke on behalf the POC and felt that Sutter should be held accountable for reducing psychiatric beds.

Pastor Daniel Solberg from Saint Paulus Lutheran said that families in Western Addition are seeing an increase in recent war veterans with PTSD.

Minister Andreus Pielhoop from German Evangelical Lutheran Church-St Matthews provides night ministry. Not many worshipers welcome unbathed disheveled homeless person sitting next to them. He believes there ought to be a strong community response to Sutter/CPMC for the breached agreements of psychiatric beds and inpatient services.

Member of the public who works for Westside Crisis Services supported the resolution and felt that there is not enough collaboration among providers and there is a need for aftercare follow up.

Member of the public who is with SF Cares endorsed the resolution. She mentioned that a hospital rationalized the denial of an in-patient bed to a woman with acute mental illness with the excuse that the woman was deemed to be not seriously ill enough!

Ms Miller empathized with what the public just expressed. She pointed out the board does not have the power to change Sutter Health/CPMC and urged the public to take a step father by going the BOS. She said that power concedes nothing without demand.

Dr. Patterson said that board members need to keep individual supervisors abreast of public concerns. He wanted clarification on psychiatric beds from Dr. Geoffrey Wilson.

Dr. Geoffrey Wilson said that at SFGH there are 19-20 acute beds on 7A, 12 acute beds on 7B and 19 acute beds on 7C.

Dr. Patterson wanted to know about beds for minors with acute psychiatric illness.

Dr. David E. Lewis stated that Sutter Health plans to spend about \$2.5 billion dollars. He urged the public to bring the issue to the BOS meetings, which occurs every Tuesday and asked them go contact their district supervisors.

Ms. Virginia Lewis mentioned that yesterday she and Dr. David E. Lewis attended the BOS meeting. Supervisor Jane Kim wanted more information on psychiatric care in San Francisco. She applauded the work of the Physicians Organizing Committee.

PROPOSED RESOLUTION (MHB 2013-XX): Be it Resolved that the Mental Health Board congratulates California Pacific Medical Center (CPMC) in reaching a tentative development agreement with the City of San Francisco but also strongly urges the City to ask CPMC to restore previously eliminated inpatient Psychiatric Beds and offer more support for community mental health services as part of Sutter Health's rebuilding of St. Luke's hospital and the new construction of their Cathedral Hill hospital.

WHEREAS, the need within San Francisco for both inpatient psychiatric hospital beds and outpatient community mental health services exceeds their current availability.

WHEREAS, the costs to the community of untreated mental illness are tragic including domestic abuse, school violence, substance abuse, homelessness, emergency room visits, suicide plus all the resulting and outward radiating trauma impacting surrounding family and friends.

WHEREAS, CPMC's non-profit tax exempt status earns it close to \$90 million annually in tax exemptions in San Francisco.

WHEREAS, non profit hospitals as part of their community benefit obligations must provide their fair share of mental health as well as medical health services.

WHEREAS, four years after acquiring St. Luke's in 2001 from the Episcopal Diocese, CPMC's parent company Sutter Health closed St. Luke's 32 bed inpatient psychiatric unit which violated a brokered agreement with the state attorney general's office and despite unanimous opposition from the San Francisco Health Commission, leaving St. Luke's without any psychiatric beds.

WHEREAS, this new development agreement does not provide for any restoration of these inpatient psychiatric beds and leaves both St. Luke's and Cathedral Hill hospital without a single psychiatric bed.

WHEREAS, San Francisco General Hospital's Psychiatric Emergency Services (PES) unit is often crowded beyond capacity and consequently forced to turn away patients.

THEREFORE, BE IT RESOLVED that the Mental Health Board of San Francisco urges the Board of Supervisors and the Mayor to ask Sutter Health and CPMC to restore a minimum of 38 inpatient psychiatric beds at either St. Luke's and/or their

new Cathedral Hill hospital plus provide funding for follow up community residential care and also provide more support for community mental health programs all of which can help reduce the need for inpatient treatment.

No quorum for necessary vote tonight.

ITEM 5.0 ELECTION OF OFFICERS

5.1 Public Comment

5.2 Report from Nominating Committee

The Nominating Committee stated the nominees at the November 15, 2012 meeting as: Co-Chairs: Dr. Terence Patterson and Virginia Lewis, Co-Vice Chair: Ellis Joseph and Wendy James; Secretary: Dr. David E. Lewis. Since then, Dr. Patterson and Ms. Lewis decided not to run for Co-Chairs. In their place, Mr. Joseph and Dr. Lewis offered to run for Co-Chair. Ms. James will still run for Vice Chair and Ms. Lewis has volunteered to run for Secretary. Additional nominations can be taken from the floor at this time.

5.3 Election of Officers

This item was tabled due to lack of quorum.

ITEM 6.0 REPORTS

6.1 Report from the Executive Director of the Mental Health Board.

Ms. Brooke announced that the 2012-2013 Program Review schedule is in process and we have five programs line up in the next few weeks. Loy will be handling the program review arrangements.

She focused on appointments to the board by David Chiu, Mark Farrell, Malia Cohen, and the Rules Committee.

6.2 Report from the Chair of the Mental Health Board and the Executive Committee.

Ms. Argüelles said "As all of you know, I have a daughter with mental illness. Sometimes she will sign a consent form that gives me permission to talk to her doctors or programs and other times she won't. So I want to share a very important option for family members to at least be able to provide information to our loved one's providers even if we can't have a discussion. This form is in your packet and also available for the public. It can be faxed 24/7. You won't get a response back because that would violate privacy but you are able to share critical information that might help your family member."

Ms. Robinson explained that the form is an adjunct to help patients get better treatment. She pointed out that when people in the middle of psychiatric crisis, often they may omit important information to providers.

Ms. King added that notations on certain detrimental side effects of medications are important to attending clinicians.

Dr. Geoffrey Wilson said that medication notations are important to health care providers.

Ms Argüelles said that this will be the last board meeting that she chairs for the Mental Health Board. She has been on the board since 2008 and really enjoyed the experience

She said that she is expecting her seat to be filled at the Rules Committee Hearing on March 21st, so this will be my last official meeting. However, she will be at the April meeting to say a formal farewell.

The Executive committee meets Thursday, February 21st at 6:30 at 1380 Howard Street in Room 515. All board members are welcome to attend the meeting as well as members of the public.

6.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

No discussion

6.4 Report by members of the Board on their activities on behalf of the Board.

Dr. David E. Lewis reported that he has been working closely with the BOS and with MHSA to create a Mental Health Policy Committee.

6.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

Ms. Miller hoped the board will go forward on the Trauma Summit report by inviting District 10 people in to talk about their first hand experiences and by advocating more services for the district.

Ms. Virginia Lewis would like a presentation from the Physicians Organizing Committee.

Dr. David E. Lewis wanted a presentation about peer-run crisis respite.

Ms. Virginia S. Lewis would like to have a psychiatrist on the board.

6.6 Public comment.

Ms. Jackson suggested clinicians should include mental health care as a part of the annual checkup for children and mental health screening for everybody should become normative care.

Member of the public explained that feelings of anxiety, depression and loneliness, panic, anger, frustrations and depression co-occur and manifest themselves in times of crisis. As they move through challenging thoughts, feelings and impulses, people still need non-medical alternatives in a comfortable, non-judgmental environment to empower themselves to explore viable options to reduce their susceptibilities to the pressures that cause overwhelming emotional distress in the first place.

ITEM 7.0 PUBLIC COMMENT

Ms. Nancy Cross proposed annual audits on homeless shelters and SRO's. For example, an audit on how nutritionists address food. She believes that the building inspectors don't address windows.

Member of the public requested the board to consider adult bullying in work place.

ADJOURNMENT

Meeting adjourned at 9:02 PM.

Trauma Summit Report to be included in the final minutes

The Impact of Community Violence and Trauma on Youth and Families

"Violence is the leading cause of years of life lost in Bayview Hunters Point, as well as the leading cause for black men in San Francisco....Adolescents and young adults experience the highest homicide rates....Root causes of violence include poverty, oppression, mental health and family dynamics. Risk factors include witnessing acts of violence, access to firearms, alcohol use, incarceration, media, and community deterioration. All of these causes and risk factors for violence are present in Bayview Hunters Point. Among males in 94124"¹

-Mitchell Katz
*Recommendations for Improving the
Health of Bayview Hunter's Point Resident*

Since the mid 1980's the Southeastern Section of San Francisco, currently known as District 10, has been plagued with overwhelming violence that has personally affected almost every member of this close-knit, working class community. Every homicide impacts the families, friends, and neighbors of each perpetrator and victim in a manner that, until recently, has not been tangible or quantifiable. The cumulative impact of these homicides is a general sense of trauma experienced by the entire community. Lack of acknowledgment and services for mental health and healing needs of the families, witnesses, and neighbors, of both victims and perpetrators further compounds the trauma by silently conspiring with it.

Community violence has a devastating impact on young people because it challenges their basic belief that the world is safe, predictable, and controllable. Community violence threatens formation of healthy attachments and erodes children's capacity to experience trust, develop self-confidence and autonomy (Garbarino et al., 1992), and is one of the strongest predictors of aggression among youth (Attar, Guerra, & Tolan, 1994; Bell & Jenkins, 1993; Gorman-Smith & Tolan, 1998; Osofsky, Wewers, Hann, & Fick, 1993;). According to social researcher, Elijah Anderson (1982, 1992), children, particularly adolescent boys, "must learn to negotiate with the street culture to survive and are often forced to choose between the values and behaviors of the street and those that could lead to a better future." Children learn to become violent in an effort to command respect and decrease their own vulnerability. Although much of the research regarding youth violence, focuses on peer pressure, a need for acceptance, and corrupted rites of passage rituals, violence among youth usually develops from more painful and desperate origins. Adolescents who are victimized or humiliated often relieve it by lashing out, so that violence becomes a transcending experience (Fuentes, 1998). Thus, a cycle of destruction develops where children who are victimized by violence process the trauma through victimizing other children in their environment.

When fear and violence become the norm in a community, these consistent stressors play a critical role in the development and maintenance of psychological problems (Banez & Compas, 1990). Persistent feelings of not being safe often result in a state of chronic threat, generating thoughts, feelings, and behavior characteristic of Post Traumatic Stress Disorder (PTSD) symptoms (Pynoos et al., 1996; Schwab-Stone et al., 1995). In fact, there is strong and

¹ Katz MD, Mitchell. *Health Programs in Bayview Hunter's Point & Recommendations for Improving the Health of Bayview Hunter's Point Residents*. San Francisco Department of Public Health, 09/19/2006

consistent relationship between exposure to community violence and PTSD symptomatology (Kliwer, Lepore, Oskin & Johnson, 1998; Mazza & Reynolds, 1999). More than one quarter of children exposed to trauma develop Post Traumatic Stress Disorder. (Amaya-Jackson, 1995; Perry & Azad, 1999). This phenomena has reached such dramatic proportions that PTSD is becoming a common diagnosis among young, African American males, nationwide.

Studies reveal that 30–40% of youth exposed to community violence develop Post Traumatic Stress symptoms such as re-experience (nightmares, intrusive thoughts, and flashbacks), avoidance of traumatic triggers and emotional numbing (constriction of affect) and physiological hyperarousal (hypervigilance, insomnia, behavioral problems; Berman, Kurtines, Silverman, & Sarafini, 1996). These symptoms impact behavioral and emotional development as well as academic performance (Carrion, Weems, Ray, & Reiss, 2002). Moreover, the physiological consequences of stress affect not only mental health, but have been shown to correlate with non-psychological medical conditions (Dong et al., 2004; Dube et al., 2009).

Youth in Southeastern section of San Francisco, including Bayview Hunters Point, Potrero Hill, and Visitacion Valley, particularly African American boys and young men, suffer from overwhelming rates of what is referred to as Ongoing Traumatic Stress Disorder ("OTSD"). Data from clinics in Bayview Hunters Point reveal that 67% of youth have been exposed to at least 1 Adverse Childhood Experience (ACE), with 12% of patients exposed to > 4 ACEs (a critical threshold). Children with a > 4 ACEs have twice the odds of being overweight/obese and 32.6 times more likely to have learning/behavior problems in school (*Journal of Child Abuse and Neglect*, 6/2011). Research reveals a strong dose response relationship between the breadth of exposure to abuse or household dysfunction during childhood and multiple risk factors for several of the leading causes of death in adults. Disease conditions including ischemic heart disease, cancer, chronic lung disease, skeletal fractures, and liver disease, as well as poor self-rated health also showed a graded relationship to the breadth of childhood exposures. The findings suggest that the impact of these adverse childhood experiences on adult health status is strong and cumulative. Bayview Hunters Point residents experience high numbers of chronic illness, depression and premature mortality (SF Healthy Homes Project "Community Health Status Assessment").

Fortunately, there is new attention and research devoted to the impacts and treatment around trauma related to community violence, particularly within the Southeastern Section of San Francisco. Barbara Garcia, Director of San Francisco Department of Public Health has identified trauma services and health disparities among African Americans in San Francisco as among the top three priorities for the department. Dr. Nadine Burke Harris' Center for Youth Wellness, in partnership with the Stanford Early Life Stress Research Program (ELSRP), part of the Department of Psychiatry and Behavioral Sciences in the Division of Child and Adolescent Psychiatry at Stanford University, has been working to develop and implement a multidisciplinary approach focused on improving health outcomes for children exposed to adverse childhood experiences (ACEs) and chronic stress.

With the City's commitment to providing resources and attention to the issue of trauma related to community violence, new research and treatment methods, and the ongoing commitment to various community members, service providers, and survivors, to provide healing services, this is an opportune time to implement comprehensive strategies to decrease community violence and suffering, while improving the physical and mental health of community members that have been impacted by violence.

Trauma in San Francisco's Southeast Sector: By The Numbers

"Homicide is primarily a problem of the young, as judged by the age of the victims. Young adulthood is a dangerous period for young black San Franciscans."

-Trauma Foundation
Profile of Injury in San Francisco

For calendar year 2012, there were 69 homicides (63 incidents) and 315 shootings that injured 141 people. Over 39% of the shootings and 25% of homicides occurred in Bayview Hunters Point. Shootings are often the most revealing measure of violence as homicide, particularly in Bayview Hunters Point; as, the nearby San Francisco General has the best trauma ward in the country. Furthermore, 53% of homicide victims and 63% of shooting victims were African American, with 39% between the ages of 18-25 years old.

These extremely high rates of shootings and homicides have had a particularly devastating impact on the community, resulting in ongoing, historic, and specific trauma. According to data compiled by the San Francisco Department of Public Health (DPH), in March 2013, over 44.33% of District 10 residents who have come to a clinic for services reported that they have been exposed to at least one trauma, versus 36.45% in other areas. There is also a significantly higher incidence of both PTSD and exposure to trauma in D10 as compared to other areas. The incidence of PTSD was 17.70% for residents of D10 as compared to 14.20% in other neighborhoods. It is important to note that these statistics only capture data from people who have actually come in to a DPH clinic seeking mental health services. It is suspected that the actual impact and number of people exposed to trauma, community wide, is actually significantly higher. Additionally, PTSD is a very specific diagnosis with specific symptoms. Not everyone who is exposed to trauma suffers from PTSD. Often times, exposure to trauma results in more common diagnoses, including depression, anxiety and substance abuse.

In fact, depression is the most prevalent issue affecting these clients from District 10 with 66.5% of clients having depressive symptoms at an actionable level. Anxiety is next most prevalent (51.7%) followed by Adjustment to Trauma (40.5%). Nearly half (48.1%) had Substance Abuse as an actionable item. In the Life Domain Functioning domain, Family Functioning is an actionable problem for 45.2% of clients, followed by Social Functioning (36.4%), Employment (31.8%), and Physical/Medical problems (25.6%). Just over 10% of these clients were classified as a Danger to themselves, and 8.1% had Criminal Behavior at an actionable level.

While these statistics paint a very troubling picture of the mental health of many D10 residents, they also bear out what the attendees of the D10 Trauma Summit know: With support our community can heal.

Adult Needs and Strengths Assessment (ANSA) is an instrument that the Adult/Older Adult System of Care uses to rate client and family needs and strengths since 2010. Comparing the profile of the initial ANSAs to the ANSAs conducted subsequently shows many positive outcomes for D10 clients. In terms of Strengths, the proportion of people who had strong levels Optimism increased from 46.0% to 49.4% and Community Connection increased from 36.1% to 42.7%.

In the Needs domains, the proportion of people with Substance Abuse as an actionable problem decreased from 48.1% to 38.8%, the proportion of people with actionable levels of Depression decreased from 66.5% to 46.2%, Anxiety decreased from 51.6% to 38.0%, and Adjustment to Trauma decreased from 40.4% to 25.7%.

In the realm of Life Domain Functioning, the proportion of clients with Family Functioning as an actionable need decreased from 45.1% to 39.2%, Social Functioning as an actionable need decreased from 36.3% to 31.6%. The proportion with Physical/Medical actionable needs decreased from 25.5% to 20.8% and the proportion of clients with Employment as an actionable need decreased from 31.8% to 23.1%.

The proportion of clients at risk decreased as well. Danger to Self decreased from 10.8% to 5.8% and Criminal Behavior decreased from 8.0% to 4.7%.

These profiles suggest that time spent in treatment for residents of District 10 is yielding positive outcomes. Over 60% of District 10 residents are actively involved with the treatment process, which is consistent with mental health clients nationwide. The overall picture painted by these statistics is that D10 residents are disproportionately impacted by violence and mental health disorders resulting from the violence; moreover, with treatment and support, they demonstrate a great capacity to heal and are actively engaged in their own healing process. It is vital that the City invest resources into this community to build the capacity of existing mental health providers and support new strategies around trauma related healing services. The Southeast Trauma & Healing Plan begins to address the existing inequities in mental health services that have contributed to the ongoing and cyclical nature of the trauma in District 10. With proper support and evaluation this model can be replicated in similar communities throughout the United States.

Southeast Trauma Summit

For over three decades violence has shattered the fabric of communities within San Francisco's Southeast Sector or "District 10". Today, what is being referred to as Ongoing Traumatic Stress Disorder (OTSD) affects the majority of young people and their families, with devastating long-term, physical and emotional impacts. While community violence and OTSD have been identified by community members, public health representatives, and the City as one of the most important issues impacting District 10, little has been done to provide systematic and sustainable healing and treatment service.

On November 13, 2012 approximately fifty providers, experts and members of the City and County of San Francisco convened for the Southeast Trauma Summit to create a practical plan to effectively address the healing needs of residents impacted by community violence and trauma within District 10. The purpose of the summit was to:

1. Identify best practices for trauma related to community violence in the Southeast.
2. Identify service providers within the Southeast Sector to provide healing and treatment for youth and families impacted by trauma related to community violence.
3. Develop strategies to shift City funding to culturally competent providers within the Southeast sector to provide treatment and healing services for trauma related to community violence.

The goal of the Southeast Trauma Summit was to gather the foremost experts in community violence and trauma within the Southeast sector to develop a systematic plan to shift resources to reliable service providers, who utilize best practices to treat and heal community members that are most impacted by community violence.

The following plan captures the dialogue and final presentations of the four groups tasked with identifying the primary issues and offering a plan to address them. Members of the summit self selected into one of four groups based on their expertise: 1) Children who are Hurt, Hurt Others; 2) Families of Victims and Perpetrators of Violence; 3) Community Impact; 4) The Role of Drugs and Alcohol in Community Violence. Interestingly, each of the groups independently identified almost identical issues and offered very similar plans. Therefore, the final plan presented in this report represents a very easily distilled composite of those plans that were developed and agreed upon by almost every professional and community member who has devoted their time, energy, and passion to working with victims, perpetrators, and survivors of community violence in District 10. It is time to begin healing the community. There is no longer the excuse that we didn't know or didn't know how.

Southeast Trauma & Healing Plan

District 10 will become a Healing & Wellness Zone that creates a community consciousness around healing and wellness, creates a shared language around trauma and mental health, and aligns existing community services and resources to ensure a coordinated system of care. The initiation and maintenance of this work will be carried out and coordinated by an independent organization that will serve as an organizing entity for existing providers, community groups, programs, and City departments serving victims and perpetrators of violence, and their families.

Healing Zone Umbrella Organization

The Healing Zone Umbrella Organization will be an independent body comprised of community-based organizations that specialize in trauma, policy makers, residents, and youth. The Healing Zone will be governed by a Board that operates from an authentic stance, be reflective of the population who experience trauma, and community driven. There will two paid staff members: the Executive Director and an Administrative Assistant who carry out the daily goals and activities of the organization. There will be a priority in hiring individuals from District 10 and/or experience working with trauma and healing in District 10. The values of the board directing trauma related services include:

- transparency
- accountability
- advocacy/lobbying
- cultural relevance

The Healing Zone organization's functions will be to:

1. **Developing Asset Map:** Research existing programs and services and create an organized layout of all service providers.
2. **Standardized Assessment:** Create a standard assessment tool and conduct an assessment of organizations that provide mental health services. Standardization of assessment and outcomes should be promoted across agencies and would require reporting on number of persons served, agency services, and outcomes.
3. **Funding & Advocacy:** The board is will oversee funding of services within District 10. Currently, the vast majority of existing funds are being allocated to mental health service providers, outside District 10, to provide trauma related services to District 10 population. The board would ensure funds are allocated to District 10 based providers and assist in increasing funding to increase capacity in existing organizations.
4. **Victims Assistance:** The Healing Zone Board will be the funnel through which all trauma related services are filtered. When a victim is identified, the board will assist in directing the individuals to appropriate services and provide a seamless hand off to District 10 agencies.

5. **Support Research & Education** on culturally-appropriate, best practices related to trauma informed care. Implement community led participatory research to ensure the community owns and takes the lead on the research that affects them.

Currently, the vast majority of mental health services are provided to residents of the Southeast Sector by mental health providers that are located outside of the community. Many of these services are not culturally competent and have poor outcomes for treating this population. Rather than resigning to low expectations and sense of hopelessness around the issue, it is City essential that officials remain committed to identifying effective strategies and that City funding is shifted to culturally competent providers, within District 10, to provide treatment and healing services for trauma related to community violence. The following best practices were identified as effective, community based practices for trauma related to community violence in District 10.

1. **Crisis Response:** Creation of multi-disciplinary teams utilizing Crisis Response Teams, victims' services, mental health clinicians and members of key hospital ER staff, spiritual staff, school staff and funeral directors:
 - Crisis response Team: A team of mental health professionals and community members trained in trauma and emergency response, who respond when violence occurs, to assist in de-escalating retaliation and further community violence and provide emergency counseling services;
 - Victim's Services: Provided to family members of victims of violence immediately after a homicide.
 - Mental Health Provider: A mental health provider who provides trauma interventions on site, at the time of first response, with follow-up services scheduled and delivered to family members and community members who were impacted by and/or witnessed traumatic event;
 - Key community and government providers work in cooperation with crisis response teams, victims services and mental health providers, key hospital ER staff, spiritual staff, school staff and funeral directors;
 - Implement standardization of mental health services for first responders (police, CRT, Victims's services and clinicians etc.) to process their own vicarious trauma.
2. **Home and Community Based Support and Intervention:** Provision of in-community groups and home visits to bring services into community.
 - In-home case management and mental health services visits to increase access, consistency and compliance with treatment;
 - The use of talking circles as groups which focus on community needs which reduce the stigma of attending a mental health group;
 - Groups utilize a model of peer and mental health professional partnership, to teach facilitation and leadership skills among peers.
3. **Community Resources** that are easily identified;
4. **Safe Houses** for families who are in danger;
5. **Strategies to Address Drugs** as self-medication for trauma, and attendant mental health symptoms of anxiety, depression, and PTSD;

6. **Greater Psych-education** within the community around parenting classes; health education, trauma, drugs, mental health and suicide/homicide/violence prevention;
7. **Wellness Models** that utilize culturally congruent arts and movement and health practices as community based interventions (dance, art, theatre, drumming, deep breathing, yoga, meditation, acupuncture, massage, and relaxation); and
8. **Trauma & Healing Training** services that are culturally congruent for service providers as well as for government agencies (teacher's, pharmacists, case workers, funeral directors, therapists, police, chaplains, emergency room workers, and physician's). Additionally, providing additional support, training and funding for the existing providers who are already utilized within the community.

The following service providers were identified within the Southeast Sector to provide culturally competent, place based healing and treatment for youth and families impacted by trauma related to community violence:

- Bayview Hunter's Point Foundation
- Bayview YMCA
- Black Coalition on Aids
- Center for Youth Wellness
- Edgewood
- Hidden Valley Ranch Program
- Hunters Point Family
- Jelani House
- Sage
- San Francisco Housing Authority
- Sojourner Truth Foster Care Center
- Southeast Crisis Response Network
- Southeast Health Center
- Third Street Youth



SAN FRANCISCO MENTAL HEALTH BOARD

Mayor Edwin Lee

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, April 10, 2013

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

6:30 – 8:30 PM

CALL TO ORDER

ROLL CALL

AGENDA CHANGES

GOVERNMENT
DOCUMENTS DEPT

APR - 4 2013

Item 1.0 ELECTION OF OFFICERS

1.1 Report from Nominating Committee

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The Nominating Committee stated the nominees at the November 15, 2012 meeting as: Co-Chairs: Dr. Terence Patterson and Virginia Lewis, Co-Vice Chair: Ellis Joseph and Wendy James; Secretary: Dr. David Elliott Lewis. Since then, Dr. Patterson and Ms. Lewis decided not to run for Co-Chairs. In their place, Mr. Joseph and Dr. Lewis offered to run for Co-Chair. Ms. James will still run for Vice Chair and Ms. Lewis has volunteered to run for Secretary. Additional nominations can be taken from the floor at this time.

1.2 Public Comment

1.3 Election of Officers

Item 2.0 PRESENTATION TO OUTGOING CHAIR

2.1 Presentation to outgoing Chair M. Lara Siazon Arguelles. Ms. Arguelles will address the board.

2.2 Public Comment

Item 3.0 INTRODUCTION OF NEW BOARD MEMBERS

3.1 Introduction of New Board Members

Ellis Joseph, Errol Wishom and Lena Miller were all re-appointed to the Mental Health Board by the San Francisco Board of Supervisors. The San Francisco Board of Supervisors then appointed Melody Daniel to Family Member Seat #13, Marlene Flores to Family Member Seat #16 and Board of Supervisors President David Chiu appointed Terezi S. Bohrer for his Public Interest Seat #4.

3.2 Public Comment

Item 4.0 ACTION ITEMS

For discussion and action.

4.1 Public comment

4.2 . PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of January 9, 2013 be approved as submitted.

4.3 . PROPOSED RESOLUTION: Be it resolved that the notes for the Mental Health Board meeting of February 13, 2013 be approved as submitted.

4.4 . PROPOSED RESOLUTION: Be it resolved that the notes for the Mental Health Board meeting of March 13, 2013 be approved as submitted.

4.5 PROPOSED RESOLUTION (MHB 2013-XX): Be it Resolved that the Mental Health Board congratulates California Pacific Medical Center (CPMC) in reaching a tentative development agreement with the city of San Francisco but also strongly urges the city to ask CPMC to restore previously eliminated inpatient Psychiatric Beds and offer more support for community mental health services as part of Sutter Health's rebuilding of St. Luke's hospital and the new construction of their Cathedral Hill hospital.

4.6 PROPOSED RESOLUTION (MBH 2013 -XX) Be it Resolved that the Mental Health Board adopts the November 13, 2012 Trauma Summit report, "The Impact of Community Violence and Trauma on Youth and Families" as a working document to guide strategy for services in the Southeast Sector.

Item 5.0 DIRECTORS REPORT

For discussion.

5.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

5.2 Public Comment

Item 6.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS For discussion.

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

6.1 Mental Health Services Act Updates

6.2 Public Comment

Item 7.0 REPORTS

For discussion

7.1 Report from the Executive Director of the Mental Health Board.

Discussion regarding upcoming events, conferences, or activities that may be of interest to board members; Mental Health Board budget issues and update on staff work on board projects.

7.2 Report of the Chair of the Board and the Executive Committee.

Discussion regarding Chair's meetings with Community Behavioral Health Services staff, meetings with members of the Board of Supervisors and community meetings about mental health or substance abuse.

7.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

Michelle Ruggels, Director of Operations, CBHS was honored at SPUR's 33rd annual Good Government Awards in March 2013 for her leadership in overseeing \$490 million in annual contracts to 200 community-based organizations that provide community health services to San Franciscans. An employee of the Department of Public Health since 1997, Michelle led the Mental Health Medi-Cal Revenue Enhancement Project in 2011, creating a certification process that allows local agencies to use federal funds instead of local general funds to support their services. The department expects this effort to save \$550,000 in fiscal year 2014 alone.

Stephanie Feldman, Women Making History Award Ceremony, Board of Supervisors. She is the Director of Comprehensive Crisis Services for CBHS. She started her work in the community at the age of 14 by participating in community health fairs, volunteering for the American Cancer Society and assisting with coordination of community programs through her church. She has spent over 18 years providing direct crisis services. She goes the extra mile to ensure that she and her team provide top-notch services to the San Francisco community especially women and children affected by crisis.

7.4 Report by members of the Board on their activities on behalf of the Board.

7.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

7.6 Public comment.

8.0 PUBLIC COMMENT

ADJOURNMENT

DISABILITY ACCESS

1. Room 278 is accessible to persons using wheelchairs and others with disabilities. Assistive listening devices, materials in other alternative formats, American Sign Language interpreters and other accommodations will be made available upon request. Please contact Darlene Daevu, Community Behavioral Health Services, 415-255-3426 or by email: Darlene.daevu@sfdph.org. Providing at least 72 hours notice will help to ensure availability. To reach a TTY line, call (415) 255-3449. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at City Hall, One Dr. Carlton B. Goodlett Place (between Grove and McAllister), in Room 278. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 71 Haight/Noriega. Also, the J, K, L, M, and N lines underground. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. Special Hearings are usually held at the Department of Public Health, 101 Grove Street, 3rd Floor, Room 300. The same public transportation options as above apply. It is wheelchair accessible.

4. For Special Hearings at other locations, please call for directions or bus information. All locations will be accessible.

5. City Hall is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on One Dr. Carlton B. Goodlett Place.

6. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415) 554-7724
Fax: 4(15) 554-5163
E-mail: sotf@sfgov.org

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from the Task Force or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: www.sfgov.org/sunshine

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: www.sfgov.org/mental_health. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

Lobbyist Registration and Reporting Requirements

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics



Edwin Lee
Mayor

SAN FRANCISCO MENTAL HEALTH BOARD

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www.sfgov.org/mental_health

Unadopted Minutes

Mental Health Board

Wednesday, April 10, 2013

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

San Francisco, CA

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MAY - 9 2013

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BOARD MEMBERS PRESENT: Ellis Joseph, MBA, Vice Chair; David Elliott Lewis, Ph D, Secretary; Terezie "Terry" Bohrer; Melody Daniel, MFT; Kara Chien, JD; Wendy James; Sgt. Kelly Kruger; Alyssa Landy, MA; Lena Miller, MSW; Terence Patterson, EdD, ABPP; and Alphonse Vinh.

BOARD MEMBERS ON LEAVE: Marlene Flores; Virginia S. Lewis, MA LCSW.

BOARD MEMBERS ABSENT: Errol Wishom

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jo Robinson, Director of Community Behavioral Health Services (CBHS); LaVaughn Kellum King, MHSA; Jo Elias Jackson; John D. Rouse, MD, Physicians Organizing Committee (POC); Brian Tseng, POC; Crystal Marsonia, Westside Community Services; Vivian Imperiale; Wendy Yu; and six members of the public.

CALL TO ORDER

Mr. Joseph called the meeting of the Mental Health Board to order at 6:33 PM.

ROLL CALL

Ms. Brooke called the roll.

AGENDA CHANGES

There were no changes to the agenda.

ITEM 1.0 ELECTION OF OFFICERS

1.1 Report from Nominating Committee

Ms. James reported that the Nominating Committee stated the nominees at the November 15, 2012 meeting as: Co-Chairs: Dr. Terence Patterson and Virginia Lewis, Co-Vice Chair: Ellis Joseph and Wendy James; Secretary: Dr. David Elliott Lewis. Since then, Dr. Patterson and Ms. Lewis decided not to run for Co-Chairs. In their place, Mr. Joseph and Dr. Lewis offered to run for Co-Chair. Ms. James will still run for Vice Chair and Ms. Lewis has volunteered to run for Secretary.

Additional nominations can also be taken from the floor at this time and you are free to nominate yourself for a position. We will take a roll call vote for each office. You are also welcome to ask to be appointed to a general seat on the Executive Committee if you would like to be more involved. And all board members are welcome to attend and participate in Executive Committee meetings, as a nonvoting member”.

1.2 Public Comment

No public comment

1.3 Election of Officers

Ellis Joseph said “We will vote for each office separately. The nominations for the office of Chair are two Co-Chairs, David Elliott Lewis and me. If elected we would share the responsibility of chair, alternating presiding over meetings and representing the board in different ways. Our terms would run to February 2014 as bylaws state that elections are in even numbered years. Any officers elected for this year would be eligible to run for a second year at that time. We are electing the current officers during an odd year due to leadership changes that altered the schedule.”

Board unanimously approved the following officers.

Congratulations to Co-Chairs Ellis Joseph and Dr. David Elliott Lewis

Congratulations to Vice Chair Wendy James.

Congratulations to Secretary Ms. Virginia Lewis.

ITEM 2.0 PRESENTATION TO OUTGOING CHAIR

2.1 Presentation to outgoing Chair M. Lara Siazon Arguelles. Ms. Arguelles will address the board.

Accepting the recognition plaque and a certificate on the behalf of Ms. Arguelles is Caroline Arguelles, who is Ms. Lara Arguelles' daughter.

Mr. Joseph said that he would like to acknowledge and thank the outgoing Chair, Lara Arguelles for her exceptional leadership of the board for the past two years.

Ms. Arguelles' letter to the board

My dear Colleagues,

I chose to email my welcome to the new Board Members and thank my former Colleagues. I want to request the board members to include this email in the minutes of the April 10, 2013 MHBSF Monthly Meeting.

It has been a privilege to serve as a Board Member of the MHBSF for two (2) terms, as Acting Chair for almost a year and as Chair for two (2) years. Thank you all for your support, and because of our "TEAM" Effort mind-set in the past years, we have accomplished a lot. Each of you volunteered your time and effort because of your passion to make a difference. Your jobs as Lawyers, ESQ., JDs, in Social Work, Teachers, and positions in any of the Service-oriented organizations or work places are all noble and commendable.

I do want to acknowledge and recognize a few members for their hard work and commitment to help others especially the disenfranchised & under represented.

- My "MVP" award goes to Sgt. Kelly Dunn. Kelly has a full time job as SFPD Officer and SFPD Mental Health Liaison, Coordinator of the SFPD Crisis Intervention Training (CIT), and a MHBSF Board of Director.*
- I want to recognize Dr. Terry Patterson for following up his promise to update Supervisor David Campos as promised.*
- I want to give credit to James Keys for his role during his term as MHBSF Chair and holding a full time job, to stop Sutter/CPMC's "takeover" of St. Luke's Hospital's.*

It is my pleasure to welcome the new Board Members, hopefully you will consider to join the Executive Committee. To my knowledge, Mental Health Board SF is the only County Board that has an Office Staff. Helynna Brooke and Loy Proffitt are both efficient, knowledgeable, and hard working. I urge you to visit your office and get to know your staff better. I want to extend my gratitude to Helynna and Loy for the jobs they have done for me personally and for the Board. You, as Board Members, can help and advance the Board's Agendas by personally taking the time to contact your Supervisors via phone calls, emails, Facebook, Twitter, and other Social Media tools/channels (at home, at your most convenient times).

Congratulations to the new Board Officers.

Best,

M. Lara S. Arguelles

2.2 Public Comment

No public comment

ITEM 3.0 INTRODUCTION OF NEW BOARD MEMBERS

3.1 Introduction of New Board Members

Mr. Joseph informed the board that on March 21st, 2013 the Rules Committee of the Board of Supervisors re-appointed him to a family member seat, Errol Wishom to a consumer seat, and Lena Miller to a mental health professional seat for our second terms on the board.

And they appointed Melody Daniel to Seat #13, the family member seat replacing Lara Arguelles, and Marlene Flores to Seat #16 for the family member seat that has been vacant since Virginia Wright left the board. Finally Supervisor Chiu appointed Terry Bohrer to his public interest seat #4, that Linda Bentley left in April 2012. He asked the new board member to say a few words to introduce themselves and share with the board why they wanted to be appointed to a seat on this board.

Ms. Daniel said that she is a mother of a child with mental illness, who is currently 42 years old. Her son had his first acute psychiatric crisis when he was 18 years old. She is in the progress of earning her MFT and is passionately advocating for the betterment of mental health services.

Ms. Bohrer is a Nurse, Social Worker, and Certified Legal Nurse Consultant, with expertise in mental health public policy.

Prior to moving to San Francisco in 2011, she was from Washington DC, Maryland was on the Governor Mental Health Advisory Community since 1976 and was the Director of Mental Health for St. Georges County.

Now, she volunteers weekly at MHA-SF for two days, sits on MHA-SF's Public Policy Committee and is a counselor for suicide prevention. She is delighted to be on the board and hopes to share her east coast experience with the board.

Dr. David Elliott Lewis said that Ms. Bohrer has been an asset at MHA-SF, because she knows a lot about mental health policies.

3.2 Public Comment

No public comment.

Item 4.0 ACTION ITEMS

For discussion and action.

Mr. Joseph said "in addition to approval of minutes and notes from past MHB meetings, the board will be voting on a resolution calling for restoration of hospital beds in San Francisco and a resolution adopting the November 13, 2012 Trauma Summit Report. Members of the Physicians Organizing Committee (POC) will provide a brief overview of the issue for both the benefit of the board members and the public. Lena Miller who organized the Trauma Summit and prepared the report will give a brief overview of the report and ways in which it can be implemented. Then we will call for public comment before voting."

Brian Tseng with the Physician Organizing Committee stated that currently in San Francisco, SFGH (San Francisco General Hospital) is the only hospital with an acute psychiatric unit that accommodates clients/patients without private insurance, since Sutter Health shut down its in-patient psychiatric unit at St. Luke's Hospital in 2007. He would like to see Sutter Health restore psychiatric hospital beds, as it promised to San Francisco in its hospital building plans and urged the board to approve the resolution.

He said POC representatives have met with most supervisors on the Board of Supervisors, except David Chiu, president of the BOS. At the last full BOS meeting, only Supervisor Jane Kim voiced the issue of mental health care inadequacy and psychiatric bed shortage for non-private insured clients/patients in San Francisco County. It is too much of a burden for SFGH to be the only hospital in the county to have psychiatric beds. Sutter Health's current proposal to rebuild St. Luke and Cathedral Hill hospitals without restoring any promised psychiatric beds for non-private insured clients/patients is unacceptable. He voiced that its non-profit status should be revoked because currently Sutter Health benefited over \$100 million in tax breaks per year.

He emphasized that Psychiatric Emergency Services (PES) at SFGH averages about 23% of the time on diversion, meaning they cannot take any new emergency psychiatric patients during those times. He said that the Central Labor Council has endorsed the resolution holding Sutter Health accountable for its breach of contract with the county.

He encouraged all mental health board members to discuss the resolution with city supervisors, Barbara Garcia, who is the health director at the San Francisco Department of Public Health (DPH) and other city and county leaders. He admitted that although inpatient psychiatry is not the main model, psychiatric beds are still needed.

Dr. John D. Rouse is a psychiatrist in the public sector since 1946 and is speaking on behalf of the POC. One of his goals is to get people with psychoses stabilized and back into the community. However, he has seen an increase in "ghettoization" of public mental health folks.

He said that before St. Luke's psychiatric unit was closed down by Sutter Health both SFGH and St. Luke's accepted any person needing in-patient psychiatric care. Now only SFGH provides in-patient psychiatric care to non-privately insured citizens. He believes that both private and non-profit hospital and other health facilities need to treat the general public with psychosis too. He has seen people coming in with mental health problems who have acute co-occurring disorder in both mental health and medical issues.

Dr. Patterson stated that he has seen enough atrocities of not having mental health care. He asked about the private psychiatric beds – meaning privately insured beds not generally available to homeless person with mental illness or Medi-Cal patients/clients.

Dr. John D. Rouse said CPMC campus has 23 privately insured beds in an unlocked unit.

Ms. James wanted to know if California State law has any mandatory regulation regarding the allocation of non-privately insured psychiatric bed based per population.

Dr. John D. Rouse said there is no mandatory requirement. But there has been a movement for community and clinical services. He said the public ought to contact the state to demand that the Office of Statewide Planning and Development to have a better mental health care infrastructure.

Brian Tseng added that communities ought to respond with urgency to San Francisco leaders and the BOS about non-private psychiatric bed restoration because Sutter Health is fast tracking the building projects.

Ms. James asked about care costs.

Dr. John D. Rouse stated that private cost is expensive and labor intensive and not scalable. Homeless people often have multiple co-occurring disorders. Medi-Cal has a very stringent qualification definition in determining eligibility for psychiatric care.

Mr. Vinh wanted to know the actual connection between CPMC and Sutter Health.

Dr. John D. Rouse stated that Sutter Health is the parent company that owns both CPMC and St Luke's Hospital.

Ms. Bohrer wanted to know the total number of psychiatric beds in San Francisco.

Dr. John D. Rouse said that SFGH has 51 beds, St. Francis' Hospital has 16-26 beds, CPMC has 23 non-critical beds and Langley Porter Psychiatric Institute at the University of California, San Francisco has 20 beds.

Dr. David Elliott Lewis thanked the POC representatives for talking and educating the BOS on the issue.

4.1 Public comment

Ms. Jo Elias Jackson stated that mental illness should be decriminalized and pleaded to the board to pass the resolution on psychiatric bed restoration.

4.2 . PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of January 9, 2013 be approved as submitted.

Unanimously approved

4.3 . PROPOSED RESOLUTION: Be it resolved that the notes for the Mental Health Board meeting of February 13, 2013 be approved as submitted.

Unanimously approved

4.4 . PROPOSED RESOLUTION: Be it resolved that the notes for the Mental Health Board meeting of March 13, 2013 be approved as submitted.

Unanimously approved

4.5 PROPOSED RESOLUTION (MHB 2013-XX): Be it Resolved that the Mental Health Board congratulates California Pacific Medical Center (CPMC) in reaching a tentative development agreement with the city of San Francisco but also strongly urges the city to ask CPMC to restore previously eliminated inpatient Psychiatric Beds and offer more support for community mental health services as part of Sutter Health's rebuilding of St. Luke's hospital and the new construction of their Cathedral Hill hospital.

Unanimously approved

4.6 PROPOSED RESOLUTION (MBH 2013 –XX) Be it Resolved that the Mental Health Board adopts the November 13, 2012 Trauma Summit report, "The Impact of Community Violence and Trauma on Youth and Families" as a working document to guide strategy for services in the Southeast Sector.

Unanimously approved

ITEM 5.0 DIRECTOR'S REPORT

5.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

Please see the attached April 2013 Director's report.

Ms. Robinson highlighted/reported the following items included in the April Director's report.

She encouraged board members to attend the MHSA Advisory Board meeting which is next Wednesday April 17, 2013 at 3 PM at the California Institute o Integral Studies (CIIS) on the 5th Floor.

She warned the board over the proposed budget cuts and would like the board to attend a couple of upcoming budget meetings. The April 22, 2013 meeting at 3 PM at 101 Grove Street in room 300 is stakeholder meeting with Barbara Garcia who is the health director for the San Francisco Department of Public Health. And the following day is the San Francisco Health Commission meeting on April 23, 2013 at 4 PM. She felt that representation from the board during the budget process would be valuable for, and to, many community programs and services.

Following her report, Ms. Robinson provided an overview of the Department of Public Health and Community Behavioral Health Services. The power point is at the end of the report.

Monthly Director's Report **April 2013**

1. New Spanish-language Brochure for Clients

Determining whether you have a mental or substance use disorder is the first step to seeking and receiving treatment. The Spanish-language version of *Should You Talk to Someone About a Drug, Alcohol, or Mental Health Problem?* is a consumer brochure that contains a series of questions people can ask themselves to help them decide whether to seek help for a mental or substance use

disorder (or both). The brochure urges those who answer “yes” to any of the questions listed to seek help and provides resources on where to find more information.

The brochure is available at <http://store.samhsa.gov> or through the link below:

<http://store.samhsa.gov/product/Deberia-usted-hablar-con-alguien-sobre-un-problema-relacionado-con-las-drogas-el-alcohol-o-la-salud-mental-/SMA12-4731>

2. Mental Health Partners Share Strategies to Fight Stigma

Over 300 participants convened in San Francisco for the 2013 “Tools for Change Conference” presented by the Mental Health Association of San Francisco’s Center for Dignity, Recovery and Stigma Elimination. The first-of-its kind conference which took place March 21st-22nd brought together community-based programs, consumers and families, county and state agencies, and leading national experts to share knowledge and skills to effectively reduce mental health stigma and discrimination. Workshops were provided by CalMHA Stigma and Discrimination Reduction (SDR) Program Partners, CalMHA county members, and SDR experts like Dr. Patrick Corrigan of the National Consortium on Stigma and Empowerment. Participants networked, exchanged best practices and gained skills to be effective change agents in their communities. Participants were also exposed to the critical importance of building pathways to cultural responsive stigma reduction and the work of Dr. Lawrence Yang and the Mental Health Association of San Francisco’s Promising Practices SDR Program. For more information on next steps from the conference or conference material contact: Luba Botcheva at luba@mentalhealthsf.org or Stephanie Welch at stephanie.welch@calmha.org.

3. Center for Medicaid and CHIP Services Issues Information Bulletin to States Emphasizing Importance of the Early Screening Part of EPSDT for Mental Health, Substance Use Conditions

The Center for Medicaid and CHIP Services (CMCS) this week issued an Informational Bulletin http://www.cmhda.org/go/portals/0/cmhda_files/breaking_news/1303_mar/cms_letter_epsdt_3-27-13.pdf to inform states about resources available to help them meet the needs of children under EPSDT, specifically with respect to mental health and substance use disorder services. According to the notice, “Prevention and early identification of health conditions, which is a key component of EPSDT, promotes positive health outcomes and can reduce health care costs across an individual’s lifespan.” The bulletin further reminded states that the EPSDT program assures that health problems, including mental health and substance use issues, are diagnosed and treated early before they become more complex and their treatment more costly. Under the EPSDT benefit, eligible individuals must be provided periodic screening (well child exams) as defined by statute. One required element of this screening is a comprehensive health and developmental history including assessment of physical and mental health development. If, during a routine periodic screening, a provider determines that there may be a need for further assessment, an individual should be furnished additional diagnostic and/or treatment service. In addition to the required periodic screens, EPSDT provisions ensure that children receive medically necessary physician screenings in order to detect a suspected illness or condition not present or discovered during the periodic exam. The screening may also trigger the need for a further assessment to diagnose or treat a mental health or substance use condition.

4. OSHPD Announces Community Forums on Workforce Education and Training Five-Year Plan

The Office of Statewide Health Planning and Development (OSHPD) announced today (3/29/13) that it plans to convene numerous community forums to solicit feedback on the next Mental Health Workforce Education and Training (WET) Five-Year Plan, 2014-2019. This Five-Year-Plan guides the development of public mental health workforce strategies – at state, regional and local levels – toward an integrated mental health service delivery system. Via 14 community forums, OSHPD seeks feedback on:

- Engagement and employment of mental health consumers and family members in the mental health workforce;
- Engagement and employment of diverse, racial, ethnic, and underrepresented communities in the mental health workforce;
- Incentives to recruit and retain students to mental health careers;
- Education and training programs for mental health providers (expansion, curriculum);
- Reduction of stigma associated with mental illness in the workforce; and
- Regional collaboration on mental health workforce development strategies.

For further information, contact Elvira Chairez at Elvira.Chairez@oshpd.ca.gov or (916) 326-3635.

5. “Each Mind Matters” Unifies Mental Health Movement (funded by CalMHSA and Proposition 63)

CalMHSA and Stigma and Discrimination Reduction (SDR) partner RS&E unveiled the “Each Mind Matters: California’s Mental Health Movement” tagline and logo last week. Each Mind Matters symbolizes how California is transforming its mental health systems— from the ground up. The theme will be used throughout CalMHSA efforts to promote mental health awareness, support equity for mental health care and achieve acceptance and inclusion for individuals and families living with mental health challenges. The overwhelmingly positive response from the mental health community reflects the extensive engagement of the community during development. Throughout Mental Health Month in May, we will be unveiling Each Mind Matters tools to help you promote awareness and unify our efforts across the state. Contact Stephanie Welch at stephanie.welch@calmhsa.org. CalMHSA and Stigma and Discrimination Reduction (SDR) partner RS&E unveiled the “Each Mind Matters: California’s Mental Health Movement” tagline and logo last week. Each Mind Matters symbolizes how California is transforming its mental health systems— from the ground up. The theme will be used throughout CalMHSA efforts to promote mental health awareness, support equity for mental health care and achieve acceptance and inclusion for individuals and families living with mental health challenges. The overwhelmingly positive response from the mental health community reflects the extensive engagement of the community during development. Throughout Mental Health Month in May, we will be unveiling Each Mind Matters tools to help you promote awareness and unify our efforts across the state. Contact Stephanie Welch at stephanie.welch@calmhsa.org.

6. President Obama Signs FY 2013 Funding Resolution - Across-the-Board Cut Imposed on Funding for Mental Health Research and Services (from NAMI News)

On March 26, the President signed into law the fiscal year (FY) 2013 “continuing resolution” for the remaining months of the current fiscal year, through Oct. 1, 2013. Congress passed the bill the previous week.

The bill, House Resolution 933, keeps in place FY 2012 funding levels for mental illness research, services and supportive housing programs—MINUS the 5 percent across-the-board “sequestration” cuts that were put in place last month. Veterans programs – including mental health services in the U.S. Department of Veterans Affairs (VA) – are exempt from the “sequester” reduction and will actually receive increases for the remaining months of FY 2013.

This brings an end to the debate over the FY 2013 budget – 6 months into the current fiscal year. Federal agencies including the National Institute of Mental Health (NIMH), the Substance Abuse and Mental Health Services Administration (SAMHSA) and the U.S. Department of Housing and Urban Development (HUD) will now have 30 days to submit plans to Congress on how they will impose the 5 percent cut across various programs and functions.

The federal agencies will likely cut one or a combination of the following:

- grants to states, localities and providers
- ongoing research and demonstration projects
- personnel

The stage is now set for the debate on the FY 2014 budget. Last week the House and Senate passed separate budget resolutions that set overall constraints on spending, as well as 10-year plans for long-term deficit reduction. President Obama is expected to release his proposed budget for FY 2014 on April 8.

7. Children, Youth and Families (CYF)

Children, Youth and Families has continued to develop strategy relative to four initiatives impacting care for children and youth in San Francisco.

Katie A. is the statewide mandatory implementation of mental health services for Foster Care Youth. On March 4-5, 2013 the City and County of San Francisco held a two day retreat to inform county partners and providers on the background and implications of the Katie A settlement on services for child and families in San Francisco County. The two day retreat consisted of county partners, family partners and a working summit with Community Based Intensive Services providers.

The Katie A. Core Practice Model Guide (CPM) was used as an informal guidance to refine the AIM developed throughout the retreat. CPM calls for a culturally competent, family-centered, strength based and trauma informed system that functions through the interaction of five phases or elements:

- Engagement
- Assessment
- Service planning and implementation
- Monitoring and Adapting
- Transition

At the conclusion of the summit, utilizing the data from the first day and a half the county leadership group decided to adopt a plan that integrates an attachment and trauma-focused system of service delivery within a shared framework that is information driven, integrated, and innovative to support the health, safety, permanency, and well-being of children and youth in the foster care and probation systems. The goal for this plan is to design a system that will serve children, youth and families that meet the Katie A class criteria and serve as a catalyst for improvements that will impact all children in the San Francisco County System of Care.

The Trauma/Resiliency Informed System of Care (TRISC) initiative has continued to progress. The curriculum design subcommittee has developed a framework for understanding trauma and resiliency throughout the lifespan and identified core principles, elements as well as components of a comprehensive and foundational curriculum. The focus has been on identifying universal concepts that apply to trauma in general as well as specific aspects related to the experience of African Americans in San Francisco as well as others related to historical trauma, ongoing violence, racism and economic injustice.

The current plan is finish a draft curriculum by the end of June and to vet the curriculum with stakeholders through the summer. During the summer we will develop a training and sustainability plan including large trainings, train the trainers as well as ongoing coaching and supervision models. The expectation is that we will pilot the training in disparate sections of community programs during the fall, gather and integrate the feedback and roll the training out to all of Community Programs January 2014.

Educationally Related Mental Health Services formally known as 3632 is in its second year of implementation. We are currently finalizing the MOU between San Francisco Unified School District (SFUSD) and Community Behavioral Health Services. The focus of our agreement is to serve SFUSD youth whose education has been impacted by behavioral health issues and after other less restrictive, more inclusive interventions have been applied to the problems. CBHS/CYF and SFUSD are working on developing a model of service delivery that is school-based, time limited and aligned with addressing behavioral health issues for the child, youth and/or family that are impacting educational progress. This way of working relies on two shifts in the way we have worked in the past. First we are focusing on the students Individual Education Plan (IEP) as the operating document defining the behaviors we are addressing through therapeutic intervention. Progress will then be marked by improving in the social/emotional and academic goals in the IEP. This requires clinicians to develop focused treatment plans addressing specific school based issues and/or other issues impacting school performance. Second it is best practice and least disruptive to provide these services in the context of the school environment when appropriate and space is available. This way the clinicians develop a relationship with the school as well as the student. Currently we are working on discussing this model with our staff and training the staff when appropriate.

CYF infrastructure has been impacted by past and upcoming retirements. We are currently in the process of recruiting and hiring a deputy director, an assistant director and a CYF finance director. All three of these positions have been vacant and are critical to being able to improve the system of care and implement best practices. In addition over the next 3 months the director and clinical coordinator of Foster Care Mental Health will retire. This clinic is critical to our

collaboration with HSA and our ability to implement Katie A. We will also have 4 clinicians retire during the same period of time, two of whom are Spanish speaking. We are working on replacing these positions in order to maintain our momentum and meet our obligations.

8. DPH Prevention Program Reported Effective by NIDA

<http://www.nih.gov/news/health/feb2013/nida-14.htm>

DPH Substance Abuse Prevention Services has been implementing an evidence-based program for youth and families called Strengthening Families Program (SFP) in our prevention programs since 2012. This program enhances knowledge and communication skills in teens and parents. NIH funded this program at middle schools in Iowa in 1993. A report in the American Journal of Public Health this month shows that at age 25, those children who were in SFP are 65% less likely to use or have misused prescription opioids. (Spoth et al, AJPH, 2013; NIH News, 2/14/2013)

9. A New Suicide Attempt Survivor Support Group will be Offered in San Francisco Beginning this Month

The Mental Health Association of San Francisco & the San Francisco Suicide Prevention Center are collaborating to create a unique group specifically for individuals who are suicide attempt survivors. This group will meet weekly for 12 weeks & will utilize the Wellness Recovery Action Plan (WRAP) curriculum.

- Do you have a client or know an individual that has made a suicide attempt?
- Do you know individuals who continue to struggle with thoughts of suicide?
- Do you know someone who could use support & are looking to gain tools & knowledge for wellness?

For more information about the program, please contact Jennifer Awa of the Mental Health Association of San Francisco at (415) 421-2926, x307 or jenn@mentalhealthsf.org.

10. Prevention Recovery in Early Psychosis Program (PREP)

The Prevention Recovery in Early Psychosis Program (PREP) is recruiting TAY for stipended positions on the PREP Youth Advisory Council (PYAC). This would be a great opportunity for TAY participants who are interested in mental health advocacy. Attached are an announcement with information about the PYAC and application to distribute. Please distribute to your networks. There are still a few open spots, and will keep applications open until all spots are filled. Please contact Nicole Plata if you have any questions. (See attachment 1).

11. Native American Health Centers 2nd Annual Community Water Walk

Walkers will gather at 10:30am at Stairwell #20 at Ocean Beach, adjacent to the Great Highway. The Water Walk Ceremonial will begin promptly at 11:00 am. Doctor of Traditional Medicine and Grandmother Water Walker Mona Stonefish will lead the Ceremonial Water Walk. The Water Walk reminds us of the Sacredness of the water and creates an awareness of our responsibility to care for

the water. The Water Walk reminds us our Sacred Connection with the Water and our responsibility to maintain our wellness in the physical, mental, emotional and spiritual areas of our lives. It brings us together in a good way reminding us of the importance of a healthy community.

All are welcome and encouraged to participate in and to support the Water Walk Ceremonial at Ocean Beach on May 7, 2013.

*Women, it is culturally appropriate to wear a skirt during the water walk.

Please contact Michele Maas (415) 503-1046 extension 2712 or Aurora Mamea (415) 621-4371 extension 593.

12. S.F. Painkiller Overdoses Eclipse Heroin – An Article from the S.F. Chronicle

Heroin-related deaths in San Francisco have dropped dramatically in recent years as the city has aggressively combatted the problem, but overdoses from prescription painkillers like oxycodone are skyrocketing, say San Francisco public health officials.

Fatal overdoses from heroin in San Francisco, which hit a peak of about 160 a year in the mid-1990s, have plummeted to fewer than 10 a year today, a drop that substance abuse experts attribute to the widespread availability of treatment programs as well as an antidote that reverses the effects of heroin overdose.

For the same reasons, fewer people are winding up in the hospital for heroin overdoses. Emergency rooms in San Francisco reported a 49 percent drop in heroin-related visits from 2004 to 2010, according to records from the Drug Abuse Warning Network, which monitors drug-related hospital emergency department visits.

"We're very happy it looks like we've had some success in decreasing heroin overdose deaths," said Alice Gleghorn, the Public Health Department's alcohol and drug administrator. "The bad news is it looks like there may be other drugs trying to come in and fill the gap."

The use of oxycodone, a painkiller sold under the brand name Oxycontin, jumped a stunning 528 percent from 2004 to 2010 based on emergency room visits, according to the Drug Abuse Warning Network. At the same time, non-heroin opiate use jumped 212 percent.

Prescription drug overdoses have overtaken car crashes as a leading cause of accidental death in the United States. More than 16,650 people in the United States died from prescription painkiller overdoses in 2010, according to the latest figures from the U.S. Centers for Disease Control and Prevention.

Many parts of the country have also reported increased use of heroin, spurred in part by an effort by drug companies to make abuse-proof prescription painkillers.

But, unlike San Francisco, many areas with high heroin usage have not seen a discernible drop in heroin-related deaths, Gleghorn said. "Everybody's having a problem with prescription drugs, but

we're not seeing a decrease in heroin everywhere, and certainly not the decrease in heroin deaths," she said.

Much of San Francisco's success in combatting heroin use is being credited to naloxone, a drug that is administered by nasal spray or injection. The emergency drug works to block the action of the opiate on the nerve and brain cells, counteracting the opiate's depression of the central nervous system and respiratory system. This causes an immediate and unpleasant withdrawal and reverses a potentially deadly overdose.

In 2003, San Francisco became the first California city to publicly fund the distribution of naloxone, which has saved more than 900 lives over the past decade. The city distributes kits to people likely to be in the presence of someone overdosing and trains them how to use them.

Naloxone reversed 274 overdoses in 2012, a 120 percent increase over the previous year's tally of 125, according to the Drug Overdose Prevention and Education Project, a program of the Harm Reduction Coalition, which is a national advocacy group with offices in Oakland.

Despite the city's success, heroin still remains the most common drug that sends San Franciscans into treatment.

"Clearly, heroin overdoses are happening, but people aren't dying," said Eliza Wheeler, manager of the Drug Overdose Prevention and Education Project, known as the Dope Project.

Naloxone also works to counteract overdoses caused by prescription opiates, which include oxycodone, methadone and hydrocodone, which is sold under the brand name Vicodin. But those users aren't taking the antidote.

Only 13 of last year's 274 naloxone reversals were for prescription opiate overdoses and another 37 involved the painkillers in combination with other drugs, Wheeler said.

The reason may be that people who use prescription drugs are probably not aware of the overdose risks and wouldn't have the antidote drug available to them.

"When you say the word 'overdose' to someone on medications for chronic pain, they feel they're not at risk because overdose is associated with drugs and drug users," said Dr. Phillip Coffin, director of substance use research in the San Francisco Department of Public Health's HIV prevention section. "Most don't think of themselves as drug users. They feel they're taking pain medications prescribed by their doctors."

San Francisco is now developing programs to get naloxone kits into the hands of patients receiving painkillers for chronic pain, Coffin said. He said the kits should be considered a safety precaution.

"Having the antidote on hand is both a way to be safer should an overdose occur and it's a way to help people recognize that this medication, however beneficial it may be, carries risks well," he said.

Read more: <http://www.sfchronicle.com/health/article/S-F-painkiller-overdoses-eclipse-heroin-4401624.php#ixzz2PvRVRxW>

13. Community Behavioral Health Services (CBHS) Naloxone for Opioid Overdose Prevention and Education Project

In 2009, drug overdose deaths surpassed motor vehicle crashes as the leading cause of unintentional injury deaths in the United States. The number of opioid analgesic overdoses more than quadrupled from 1999 to 2010 in the United States.¹ In a San Francisco sample, almost 1 out of 4 injection drug users reported a heroin overdose in the last year.² In this same population of young injectors, using heroin in the last 30 days constituted the highest risk of death over the ten year period.³

Naloxone, an opioid antagonist, is the antidote to opioid overdose. It can be given intranasally or injected. In the absence of opioids naloxone has no clinical effect, making it a safe medication for non-medically trained persons to use. The San Francisco Drug Overdose Prevention and Education (DOPE) project has distributed naloxone to injection drug users since 2003. After 6 years of follow up, 1,942 patients were trained and dispensed naloxone which was used in 399 overdose events. Overdoses were successfully reversed 89% of the time.⁴

Similar programs have been implemented in other communities. In a rural county in North Carolina, a multifaceted overdose prevention program targeting prescription opioids (Project Lazarus) provided naloxone to patients with risk factors for opioid-induced respiratory depression.⁵ The overdose death rate in this county dropped from 46.6 per 100,000 in 2009 to 29 per 100,000 in 2010. A recent survey of naloxone programs across the United States found 48 respondent programs that trained and distributed naloxone to 53,032 persons. This resulted in 10,171 overdose reversals.⁶

Two of the risk factors for opioid overdose are history of a mental illness or a substance use disorder.⁷⁻⁹ In order to target these high risk populations and expand access to naloxone in San Francisco County, Community Behavioral Health Services adopted a naloxone distribution program on October 4, 2012. Core components of the program include full CBHS formulary status, availability of provider and patient education materials, and in-clinic distribution. Naloxone distribution occurs in two settings, the CBHS Pharmacy and clinics. At the pharmacy, psychiatric clinical pharmacists have a collaborative practice agreement to prescribe intranasal naloxone to clients enrolled in the buprenorphine and methadone maintenance clients it serves. In addition, the pharmacy fills naloxone prescriptions for other programs including the Treatment Access Program and Office-Based Buprenorphine Induction Clinic. The other naloxone distribution sites are the CBHS mental health clinics, where intranasal naloxone is floor-stock for in-clinic dispensing. To date, the CBHS programs have dispensed approximately 40 naloxone kits and have had 2 reported opioid overdose reversals. This indicates that a naloxone distribution program targeting this at risk population has the potential to save many lives.

References

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3. Evans, J.L., et al., Mortality among young injection drug users in San Francisco: a 10-year follow-up of the UFO study. *Am J Epidemiol*, 2012. 175(4): p. 302-8.

4. Enteen, L., et al., Overdose prevention and naloxone prescription for opioid users in San Francisco. *J Urban Health*, 2010. 87(6): p. 931-41.
5. Albert, S., et al., Project Lazarus: community-based overdose prevention in rural North Carolina. *Pain Med*, 2011. 12 Suppl 2: p. S77-85.
6. Center for Disease, C. and Prevention, Community-based opioid overdose prevention programs providing naloxone – United States, 2010. *MMWR Morb Mortal Wkly Rep*, 2012. 61(6): p. 101-5.
7. Dunn, K., et al., Opioid prescriptions for chronic pain and overdose: a cohort study. *Ann Intern Med*, 2010. 152: p. 85-92.
8. Braden, J., et al., Emergency department visits among recipients of chronic opioid therapy. *Arch Intern Med*, 2010. 170(16): p. 1425-32.
9. Bohnert, A., et al. Association between opioid prescribing patterns and opioid overdose-related deaths. *JAMA*, 2011. 305(13): p. 1315-21

14. CSPP-Alliant / DPH Office of Quality Management Research Practicum

The Office of Quality Management (OQM) for Community Programs is in its fifth year of implementing a doctoral student Research Practicum in collaboration with the California School of Professional Psychology (CSPP), located within Alliant International University.

CSPP faculty screen PhD-track student applicants for placement within a year-long research practicum in the Research & Evaluation unit of OQM. The students are interviewed by OQM staff, and three are selected each year for the practicum. Students are paired with a supervisor who is working on a DPH project that could provide students with hands-on experience conducting research and evaluation in the Department. Students commit to work 8-10 hours a week for a full year, and receive a stipend from DPH that is matched by Alliant.

Students have helped with evaluation of many DPH initiatives, including evaluations of the implementation of Seeking Safety groups, the effectiveness of Dialectical Behavior Therapy, the Community Justice Center's Violence Intervention Program (ongoing), trauma among youth clients based on the Child and Adolescent Needs and Strengths assessment, a state-mandated EPSDT Performance Improvement Project, the Prevention and Recovery in Early Psychosis project (PREP), Mental Health & Substance Abuse Integration, the AIIM Higher collaboration with Juvenile Probation, assessing CBHS providers' Recovery Knowledge of CBHS providers (ongoing), and others. Several students have gone on to conduct their dissertations based on their research practicum studies and have presented results at local meetings and national conferences.

Currently we have three students working with us: Anastasia Finch, Caitlin Nevins, and Annisayah Alamsyah. Ms. Finch is working on a project to identify trajectories of "overlap" (foster care and mental health) youth using the Shared Youth Database. Ms. Nevins is working on a project to create electronic clinical alerts based on ANSA and other client data, and Ms. Alamsyah is analyzing years of CBHS client satisfaction data to find correlates of client satisfaction and functional outcomes. We look forward to another year of partnership with CSPP in the implementation of the mutually beneficial practicum program.

15. The Office of Statewide Health Planning and Development (OSHPD) to Hold in the Mental Health Workforce Education and Training (WET) Program Community Forums

The Office of Statewide Health Planning and Development (OSHPD) invites you to participate in the Mental Health Workforce Education and Training (WET) Program community forums. These community forums will engage stakeholders to provide feedback on the next Mental Health WET Five-Year Plan. The Mental Health WET Five-Year-Plan provides a framework on how to improve and develop mental health workforce education and training programs at the County, Regional, and State Levels.

OSHPD seeks feedback on:

- Engagement and employment of mental health consumers and family members in the mental health workforce;
- Engagement and employment of diverse, racial, ethnic community, and underrepresented individuals in the mental health workforce;
- Incentives to recruit and retain students to enter mental health careers;
- Education and training programs for mental health providers (expansion, curriculum);
- Reduction of stigma associated with mental illness in the workforce; and
- Regional collaboration on mental health workforce development strategies.

The regional workshop will be held on May 15, 2013 at the San Leandro Public Library, 300 Estudillo Avenue, San Leandro, CA.

Target audience includes, but is not limited to: mental health providers, educators, consumer and family members, individuals from multi-cultural communities, county mental health directors/administrators, county mental health contractors, and workforce development leaders and staff. Community forums are not limited to members of the counties the meetings will take place in. We invite members of surrounding counties to also attend and provide us feedback.

Please RSVP to OSHPD.MHSAWET@oshpd.ca.gov or (916) 326-3635 indicating your name, organization, and community forum you will be attending. If you have any questions, please contact Elvira Chairez at Elvira.Chairez@oshpd.ca.gov or (916) 326-3635.

16. Hot News (funded by CalMHSA and Proposition 63)

Mini-Grants Available for California Mental Health Speakers Bureaus: CalMHSA invites California mental health-focused organizations and individuals to submit an application for mini-grant funds to enhance their speaking activities to reduce stigma and discrimination of people diagnosed with mental illness. In June, 2013 CalMHSA's Stigma and Discrimination Reduction (SDR) initiative will award one-year mini-grants to allow speakers and speakers bureaus throughout California to incorporate SDR messages into speaker presentations, increase speaking placements, and provide stipend funds to individuals speaking about mental illness and SDR. Organizations of all types and sizes, particularly those whose work represents our state's rich cultural diversity, are encouraged to apply. Contact Nicole Jarred at njarred@rs-e.com for more information.

17. The Drug & Alcohol Certificate Program of City College of San Francisco

The Drug & Alcohol Certificate Program of City College of San Francisco, Health Education Department, is now accepting applications for Fall 2013. The deadline is May 17, 2013 for CBHS agencies to nominate up to a maximum of 4 employees per program. To nominate an employee(s), the 3-page Fall 2013 Nomination Form (attached to this Director's Report) needs to be completed by the employee(s)' supervisor(s), and faxed to CRAIG WENZL at (415) 452-5162.

The CCSF Drug and Alcohol Certificate Program is 38.5 unit program accredited by the California Association for Alcohol/Drug Educators (CAADE) and meets the requirements for state certification of drug and alcohol counselors. The program emphasizes a harm reduction approach to address the many factors of addiction. All classes are offered part-time in the evenings.

The nominating employer has to agree to the following:

1. Allow the student/employee to leave work early one day per week (Mondays) to get to class on time at 4pm at the CCSF campus at 50 Phelan Avenue. Employer agrees to pay employee for those hours and that employee will *not* lose pay for that time (most employers count this time as Professional Development time where employees continue to receive their pay while learning new skills).
2. Be supportive in helping their employees return to school and take classes towards their Drug & Alcohol certificate.
3. Ensure that the employee attends the mandatory orientation session scheduled for Monday, August 19, 2013 from 4-9pm at the CCSF Ocean Campus at 50 Phelan Avenue, San Francisco.

Students who enroll in the program will receive a FREE BOOK LOAN for the first two semesters, as well as a stipend upon completion of the second semester. Additionally, students receive direct links to academic support, financial aid if needed, and one-on-one support from program staff, etc. This is an excellent way to start getting state certification!

The deadline for submissions is Friday, May 17 at 5pm. Notification of acceptance into the program will be provided by May 22, and letters will be mailed to all new certificate students over the summer to prepare them for the fall. Please see the nomination form attached to this Director's Report (Attachment 2).

Past issues of the CBHS Monthly Director's Report are available at:
<http://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSdirRpts.asp>
To receive this Monthly Report via e-mail, please e-mail reanna.albert@sfdph.org

5.2 Public Comment

Wendy Yu stated that she just recently emerged from a couple of depressive episodes. She suggested that CBHS should expand mental health services like partial-hospitalization and evening – out-patient services rather than just day-time programs only.

She would like to see translators be available during family therapy. For example, her own mother does not speak English very well. The language barrier makes it very difficult for Wendy to talk about her mental illness with her own mother during family therapy sessions. Wendy felt translators for non-English families would be useful for individuals going through recovery programs.

She stated that CVE (Community Vocational Enterprise) and RAMS HireAbility programs are a good start. But for her, it has been a difficult process in finding work during the current economic hard times because available jobs tend to be for higher educated workers.

ITEM 6.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

6.1 Mental Health Services Act Updates

Ms. Robinson announced that she had no MHSA updates to report tonight.

6.2 Public comment

No public comment.

ITEM 7.0 REPORTS

For discussion

7.1 Report from the Executive Director of the Mental Health Board.

Ms. Brooke reminded everyone that there is a brief SFMHEF meeting after the board meeting to elect a new Director to the SFMHEF board.

She said that the MHB office received several letters regarding Dr. Gene Mabrey, a psychologist working part time for Bayview Hunters Point Foundation who was just laid off due to budget reasons. He has worked tirelessly for years in the African American community and is one of the very few therapists of color who was raised in the Southeast Sector. She encouraged the board to advocate that the program find additional funding to reinstate Dr. Mabrey. The letters will be included as part of the minutes.

She announced that the 2012-2013 Program Review schedule is in process. So far four programs were completed and another two are being scheduled in the next few weeks. Loy will be handling the program review arrangements. She said that he has been doing an excellent job organizing the program reviews.

She reminded the board that April 17, 2013 is San Francisco Black Infant Health Program's Open House.

She informed the board about the following upcoming SFMHEF and MHB workshops in April 2013:

1. April 15th: Social Media for Non Profits part 1, 10-1 with a free lunch at the library
2. April 18th in Oakland: Gender Responsive Theory and Trauma
3. April 22nd: Social Media for Non Profits part 2, 10-1 with a free lunch at the library.

7.2 Report from the Chair of the Mental Health Board and the Executive Committee.

The next Executive Committee meeting is next Thursday, April 18, 2013 at 6:30 pm at 1380 Howard Street, Room 515. All board members are welcome to attend the meeting as well as members of the public.

7.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

The Executive Committee would like to highlight Michelle Ruggels, Director of Operations for CBHS and Stephanie Feldman, director of Comprehensive Child Crisis Services for CBHS. Ms. Ruggels was honored at SPUR's 33rd annual Good Government Awards in March 2013 for her leadership in overseeing \$490 million in annual contracts to 200 community-based organizations that provide community health services to San Franciscans. An employee of the Department of Public Health since 1997, Michelle led the Mental Health Medi-Cal Revenue Enhancement Project in 2011, creating a certification process that allows local agencies to use federal funds instead of local general funds to support their services. The department expects this effort to save \$550,000 in fiscal year 2014 alone.

Ms. Feldman was honored by the Board of Supervisors for one of the Women Making History Awards. She is the Director of Comprehensive Crisis Services for CBHS. She started her work in the community at the age of 14 by participating in community health fairs, volunteering for the American Cancer Society and assisting with coordination of community programs through her church. She has spent over 18 years providing direct crisis services. She goes the extra mile to ensure that she and her team provide top-notch services to the San Francisco community especially women and children affected by crisis.

7.4 Report by members of the Board on their activities on behalf of the Board.

Ms. Landy did a program review of Children's System of Care on Evans. She liked their innovative programs very much. She mentioned the Adapt the WRAP, No More Funerals, Youth Outreach, Youth Peer Mentoring, and Digital Story programs.

Ms. Miller said she and Virginia Lewis did a program review of Bayview Hunter's Point Family Center Outpatient Mental Health Services.

On April 18, 2013 she will attend and represent the Bay Area Region at the annual California Association of Local Mental Health Boards and Commissions (CALMHB/C) weekend working retreat. CALMHB/C is a statewide organization that supports the work of local mental health

boards. The Association seeks to improve the quality and cultural competency of mental health services deliverable to the people of California.

Dr. Terence Patterson said that he and Ms. Argüelles went to Citywide Psychiatric Services for a site visit. The clients reported to him that they were very satisfied with Citywide's services. The program has peer outreach programs, intensive case managers and full-service partnerships.

Ms. Robinson added that Citywide Psychiatric Services is part of UCSF.

7.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

Dr. David E. Lewis suggested the care respite program and would like to invite Eduardo Vega, ED of MHA-SF.

Ms. Landy suggested inviting Bonnie Friedman of Children's System of Care.

7.6 Public comment.

Wendy Yu stated she has been with CBHS for about two-and-half years. She believed MHSA has provided great services and programs from self-help services, to money management to crisis care programs. She said that some people don't realize that they are in psychiatric crisis until it's too late.

She announced that April 20, 2013 is the Black Health Fair at California State University of San Francisco.

She also announced that this weekend is HTF (Health Technology Forum -SF Bay Area) Code-a-thon: Platforms for the Underserved. It is Saturday, April 13, 2013 at 8:00 AM - Sunday, April 14, 2013 at 6:00 PM (PDT) at 1355 Market St, Suite # 488.

ITEM 8.0 PUBLIC COMMENT

No public comment.

ADJOURNMENT

Meeting adjourned at 8:30 PM.

Ms. Robinson's power point

Ms. Brooke's submission of letters regarding Dr. Gene Mabrey

Community Behavioral Health Services

San Francisco Mental Health Board
April 10, 2013

The mission of Community Behavioral Health Services

is to maximize clients' recovery and wellness for healthy and meaningful lives in their communities.

With the belief that any door is the right door, CBHS provides:

- Information and referral services;
 - Prevention services;
 - TX support for SF's collaborative courts; and
 - Involuntary assessments, inpatient hospitalization and long-term care services for those found to be a danger to themselves or others, or who are gravely disabled due to psychiatric problem.
- Voluntary behavioral health services include:
 - Self-help, peer support;
 - Outpatient;
 - Case management;
 - Medication support;
 - Social rehabilitation;
 - Vocational rehabilitation;
 - Day treatment;
 - Dual diagnosis treatment;
 - Substance abuse services
 - Supported housing;
 - Residential care, transitional residential, sub-acute residential treatment and crisis residential treatment;
 - Money management; and
 - Crisis services
-

Overview - San Francisco Community Behavioral Health
Services – Adult/Older Adults Systems of Care
(CBHS/A/OA-SOC)

- **21,411 young adults, adults and older adults** through mental health crisis, day treatment, inpatient, outpatient and residential services.
 - **7,092 young adults, adults and older adults** through substance abuse methadone maintenance services, outpatient treatment, residential detox, and residential treatment.
-

FY 2011-12 Mental Health Clinics & Services for Adults and Older Adults

A/OA Systems of Care Mental Health Treatment Clinics

African American Alternatives	Outpatient Mental Health Services
Central City Older Adults	Outpatient Mental Health Services
Chinatown North Beach	Outpatient Mental Health Services
Mission A.C.T.Intensive	Outpatient Wraparound Services
Mission Mental Health	Outpatient Mental Health Services
Mobile Crisis Treatment Center	Crisis Intervention Services
OMI Family Center	Outpatient Mental Health Services
SFFIRST	Outpatient Mental Health Services
Southeast Geriatric	Outpatient Mental Health Services: Older Adults
South of Market MH	Outpatient Mental Health Services
South Van Ness HIV/Gender Services	Outpatient Mental Health
Sunset Mental Health	Outpatient Mental Health Services
Team II Mental Health Castro-Mission	Outpatient Mental Health Services: LGBTQI
Transitional Age Youth FSP Intensive Case Management:	TAY
Violence Intervention Program	Violence Prevention Treatment Services

FY 2011-12 Mental Health Clinics & Services for Adults and Older Adults

Admin Other Non-Billable	24,999
Adult Crisis Residential	18,073
Adult Residential	43,156
Hospital Administration	4,406
Local Hospital Inpatient	6,844
Mode 05 Non-Billable	11,467
Residential, Other	1,294
SNF Intensive	18,470
Crisis Stabilization Emergency R	95,020
Crisis Stabilization Urgent Care	35,765
Day Residential - Full Day	30,156
Mode 10 Non-Billable	67
Socialization	23,500
Vocational Services	21,597
Case Management/Brokerage	3,858,796
Crisis Intervention (CI)	431,374
Medication Support	4,064,890
Mental Health Services - Collate	231,752
Mental Health Services (MHS)	13,944,801
Mode 15 Non-Billable	992
Professional Inpatient Visit	92,430
No Entry	431,089
Total	23,390,937

**FY 2011-12 Adult & Older Adult Mental Health Clients, Aged 19 and Over:
Demographics and Top Ten Diagnoses**

Ethnicity	FY 11-12 UDC	%
Asian	3,677	20%
Black or African Descent	4,033	21%
Hispanic	2,602	13%
Multi-Ethnic	297	2%
Native American	227	1%
Native Hawaiian/Other Pacific Islander	135	<1%
Other/Unknown	561	3%
White or Caucasian	7,826	40%

Diagnosis Class	FY 11-12 UDC	%
Mood Disorders	17,860	51%
Schizophrenic/Psychotic Disorders	11,420	32%
Anxiety Disorders	3,698	10%
Adjustment Disorder	1,053	3%
Substance-Related Disorders	774	2%
Delirium, Dementia	168	<1%
Attention Deficit Disorder	141	<1%
Impulse Control Disorders	84	<1%
Personality Disorder	98	<1%
Childhood and Adolescent Disorders	51	<1%
Total:	35,347	

Top Ten Languages	FY 11-12 UDC	%
English	14,472	77%
Cantonese	1,506	8%
Spanish	1,481	8%
Russian	630	3%
Vietnamese	262	1%
Mandarin	164	<1%
Tagalog	143	<1%
Filipino Dialect	94	<1%
Korean	87	<1%
Cambodian	76	<1%
Total:	18,915	

Age	FY 11-12 UDC	%
19 to 24	1,274	6%
25 to 44	8,059	38%
45 to 60	7,959	37%
60+	4,119	19%

Gender	FY 11-12 UDC	%
Female	9,656	45%
Male	11,479	54%
Other/Unknown	191	1%

Overview

San Francisco Community Behavioral Health Services – Child, Youth & Family System of Care (CBHS/CYF-SOC)

- **6,700** children and youth received direct behavioral health services in their homes, communities, schools and in outpatient clinics
 - **14,394** children and youth were impacted by prevention including; early childhood mental health consultation, school based wellness as well as Substance Abuse Prevention and Intervention.
 - CBHS/ CYF fosters collaboration with other child serving agencies, San Francisco Unified School District, Juvenile Justice System/Probation, Department of Human Services Agency, Department of Children Youth and Families and First Five.
-

FY 11-12 Services Provided by Child, Youth and Family Mental Health Civil Service Program

CIVIL SERVICE CLINICS	
AIM High	Services for Juvenile Justice Involved Youths
Children System of Care	Family Involvement Team & Youth Task Force
Chinatown Child Development Center	Outpatient Mental Health Services
Comprehensive Child Crisis Services	24/7 Crisis Services
Education Related Mental Health Services (ERMHS)	Outpatient/Authorization Services
Family Mosaic Project	Intensive Case Management/Wrap Services
Foster Care Mental Health Services	Outpatient Services/Authorization
Mission Family Center	Outpatient Mental Health Services
Multi Systemic Therapy (MST)	Juvenile Justice Youth Services
OMI Family Center	Outpatient Mental Health Services
San Francisco Therapeutic Visitation	Outpatient HAS Reunification Services
Southeast Child & Family Therapy Center	Outpatient Mental Health Services
Sunset Mental Health	Outpatient Mental Health Services

Type of Service	FY 11-12 LOS
Admin Other Non Billable	8,687
Case Mgmt/Brokerage	910,627
Crisis Intervention (CI)	131,442
Medication Support	301,209
Mental Health Services - Collate	363,302
Mental Health Services (MHS)	2,055,649
Non Billable	25,982
Professional Inpatient Visit - M	1,223
Wrap Services	211,744
Other Non Billable	1,504
Total:	4,011,369

FY 11-12 Clients Served by Child, Youth and Family Mental Health Civil Service Programs: Demographics and Diagnoses

Ethnicity	FY 11-12 UDC	%
Black or African Descent	822	30%
Chinese	423	15%
Filipino	50	2%
Hispanic	845	30%
Multiple	43	2%
Vietnamese	38	1%
White or Caucasian	162	6%
Total:	2,383	

Diagnosis Class	FY 11-12 UDC	%
Additional Codes	288	10%
Adjustment Disorders	390	14%
Anxiety Disorders	393	14%
Childhood & Adolescent Disorders	924	33%
Impulse Control Disorders	41	1%
Mood Disorders	576	21%
Schizophrenic/Psychotic Disorders	102	4%
Sleep Disorders	15	1%
Substance-Related Disorders	17	1%
Unknown	24	1%
Total:	2,770	

Language	FY 11-12 UDC	%
American Sign Language (ASL)	2	0%
Arabic	7	0%
Cantonese	295	11%
English	1,873	67%
Mandarin	15	1%
No Entry	112	4%
Russian	4	0%
Spanish	409	15%
Tagalog	4	0%
Vietnamese	33	1%
Total:	2,754	

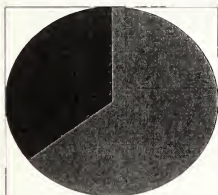
Age	FY 11-12 UDC	%
0 to 5	202	7%
6 to 12	978	35%
13 to 17	1,366	49%
18 to 22	141	5%
Total:	2,687	
Gender	FY 11-12 UDC	%
Female	984	35%
Male	1,779	64%
Unknown	16	1%

MHSA Service Categories

- Recovery-Oriented Treatment Services
 - Mental Health Promotion & Early Intervention Services
 - Peer-to-Peer Support Services
 - Vocational Services
 - MHSA Housing Program
 - Behavioral Health Workforce Development
 - Capital Facilities/Information Technology
-

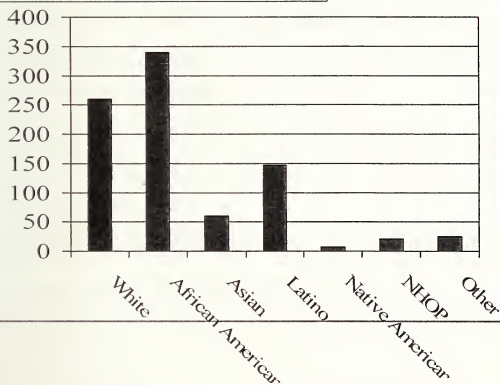
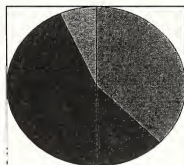
**FSP Clients
by Gender**

■ Male
■ Female



**FSP Clients
by Age**

■ CYF ■ TAY ■ Adults ■ Older Adults



**FSP Clients
by Ethnicity**

FY 11/12 Numbers* Served by Category

■ MH Promotion & Early Intervention (PEI)	56,734
■ Workforce Development	1,685
■ Vocational Services	470
■ Recovery-Oriented Treatment Services	1314
■ Peer-to-Peer Support Services	245
■ Total	59,871

*Numbers do not include individuals served in the integrated civil service programs.

1380 Howard Pharmacy

- Specialty packaged prescriptions for 11 behavioral health clinics. 508 clients/month
 - Buprenorphine maintenance for opiate addiction treatment. 206 clients/month
 - Methadone maintenance for opiate addiction treatment. 5 clients/month
 - Smoking cessation intervention. 75 clients.
 - Jail Psychiatric Services release medications 25-30 clients/month
 - E-prescribing training and user support
 - Safety net pharmacy for CBHS
-

Prescriptions for Uninsured Clients

- Provide prescriptions to uninsured clients via pharmacy benefits manager (Medimpact)
 - Access and choice to network of >120 pharmacies throughout San Francisco neighborhoods
 - 22,500 clients (duplicated), 53,394 prescriptions
 - Clients overwhelmingly satisfied based on 2011 satisfaction survey
 - Formulary management to assure optimal cost-effective medication utilization
-

Clinical Pharmacists

- Provide expertise to optimize medication use through
 - Drug information and education
 - Formulary management
 - Initiatives: reducing antipsychotic polypharmacy, metabolic monitoring, medication safety, needlestick prevention, electronic prescribing
 - Civil service clinics (SOM, CTNB, Mission, OMI, Sunset)
 - Direct client medication management including education supporting wellness and recovery
 - Medication groups
 - Smoking cessation groups
 - Substance Addiction Treatment at 1380 Howard Pharmacy
 - San Francisco Behavioral Health Center
 - Medication Safety
 - Falls Prevention
 - Transitions of Care
-

CBHS PHONE NUMBERS

Behavioral Health Access 24 hr line	(415) 255-3737
Comprehensive Child Crisis Services	(415) 970-3800
Mobile Crisis	(415) 970-4000



Visitation Valley
Community
Development
Corporation

March 11, 2013


To whom it may concern,

This letter is written on behalf of Dr. Gene Mabrey who lives and works in our community. His help and support is greatly needed and appreciated. I am a Social Worker MSW and it concerns me that he no longer has employment with the Bayview Hunters Point Foundation.

Dr. Mabrey is one of the pillars of our community, our young men look up to him and he is accessible to the community day and night. He has an open line for anyone to reach him at his home. I also live and work in the community we can reach out during the evenings after most people are gone home. He is able to comfort family members as well as the children when there is a crisis.

I certainly hope someone will look into this matter and let us know what will be done to get our helper and friend back to work. As a social worker I am certain his help is needed.

Sincerely,
Victoria Gray MSW



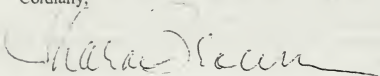
cc: Helynna Brooke Executive Director, Mental Health Board
Jo Robinson, Director of the Public Health Department
Dr. Ken Epstein, Director of children youth and families

March 11, 2013

To Whom It May Concern.

I'm writing this letter to express my appreciation in how valuable it was to have Dr. Gene Mabrey actively working in my community. I have known Dr. Mabrey for a little over 10 years now. He was once my family therapist after I had experienced some unfortunate trauma. During that time I had found out that he was the father of a girl I had went to school with which made me feel more at ease during our sessions together. Through the years I have seen him all over San Francisco in random places but seeing him as always been like a breath of fresh air to me because of who is and what he symbolizes to me. It saddens to me hear that he will no longer be working in my community due to budgets cuts and I'm praying that he's reinstated so that he's accessible to the community.

Cordially,

A handwritten signature in dark ink, appearing to read "Sharae Brown", with a long horizontal flourish extending to the right.

Sharae Brown

Family Advocate, RSSE (Reducing Stigma in the Southeast) sector of San Francisco

Sharae.Brown@sfdph.org

415.255.3701

BLACK HUMAN RIGHTS LEADERSHIP COUNCIL
OF
SAN FRANCISCO

Dr. Espanola Jackson, Founder

Robert Woods, Chairman

April 8, 2013

To whom it may concern,

This letter is being written in the behalf of a BVHP Community Gentleman & Scholar, Dr. Gene Mabrey, a community success story. I have known Dr. Mabrey since 1973 as a liaison from the Mayor Alioto's Office of Model Cities Program assigned to BVHP Community when he was a Undergraduate Student at San Francisco State University.

He was selected with Claude Everhart and several other BVHP Community Residents to attend a four year university a program under Young Community Developer. YCD was a program that was found by then BVHP Community Leaders under the Model Cities Programs for the future of the community. This community agency YCD still exist since 1973 helping the betterment of the community as designed. The purpose of his education were to serve the BVHP Community as a role model. Dr. Mabrey worth to the community goes beyond his presence as a person, he is the dream in which every resident wish for, to serve his or her community, fulfilling his obligation as a community role-model. He has kept his promise as a man to the community by being available and volunteering his service to the community when needed.

Those who made the decision to irradiate Dr. Mabrey services from the BVHP Community do not understand the investment the community has invested or the true meaning of a community benefit. The BHRLC of San Francisco Community seek full restitution and restore Dr. Mabrey whole in his position of service.

Your Truly,



Robert Woods, Chairman
BHRLC of San Francisco

cc: Dr. Espanola Jackson, Founder of BHPLC of SF
Dr. Willie Ratcliff, Bayview News





SAN FRANCISCO MENTAL HEALTH BOARD

Mayor Edwin Lee

1380 Howard Street, 2nd Floor
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@mhbsf.org
www.mhbsf.org
www.sfgov.org/mental_health

MEETING OF THE MENTAL HEALTH BOARD

Wednesday, May 8, 2013
City Hall
One Carlton B. Goodlett Place
2nd Floor, Room 278
6:30 – 8:30 PM

05-03-13A08:06 RCV0

CALL TO ORDER

ROLL CALL

AGENDA CHANGES

Item 1.0 DIRECTORS REPORT

For discussion.

GOVERNMENT
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1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public Comment

Item 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

For discussion.

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Updates

2.2 Public Comment

Item 3.0 ACTION ITEMS

For discussion and action.

3.1 Public comment

3.2 . PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of April 10, 2013 be approved as submitted.

3.3 . PROPOSED RESOLUTION (MHB- 2013-XX): That the Mental Health Board Urges the Mayor to Withdraw His Request to Cut the Department of Public Health's Funding.

Item 4.0 PRESENTATION: COMPREHENSIVE CRISIS SERVICES, STEPHANIE FELDMAN, MS, DIRECTOR AND THE "INTERRUPT, PREDICT & ORGANIZE INITIATIVE", CHARLES MORIMOTO

4.1: Presentation: Comprehensive Crisis Services, Stephanie Feldman, MS, Director, and the "Interrupt, Predict & Organize Initiative", Charles Morimoto

4.2 Public Comment

Item 5.0 REPORTS

For discussion

5.1 Report from the Executive Director of the Mental Health Board.
Discussion regarding upcoming events, conferences, or activities that may be of interest to board members; Mental Health Board budget issues and update on staff work on board projects.

5.2 Report of the Co-Chairs of the Board and the Executive Committee.
Discussion regarding Chair's meetings with Community Behavioral Health Services staff, meetings with members of the Board of Supervisors and community meetings about mental health or substance abuse.

5.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

5.4 Report by members of the Board on their activities on behalf of the Board.

5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

5.6 Public comment.

6.0 PUBLIC COMMENT

ADJOURNMENT

DISABILITY ACCESS

1. Room 278 is accessible to persons using wheelchairs and others with disabilities. Assistive listening devices, materials in other alternative formats, American Sign Language interpreters and other accommodations will be made available upon request. Please contact Darlene Daevu, Community Behavioral Health Services, 415-255-3426 or by email: Darlene.daevu@sfdph.org. Providing at least 72 hours notice will help to ensure availability. To reach a TTY line, call (415) 255-3449. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at City Hall, One Dr. Carlton B. Goodlett Place (between Grove and McAllister), in Room 278. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 71 Haight/Noriega. Also, the J, K, L, M, and N lines underground. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. Special Hearings are usually held at the Department of Public Health, 101 Grove Street, 3rd Floor, Room 300. The same public transportation options as above apply. It is wheelchair accessible.

4. For Special Hearings at other locations, please call for directions or bus information. All locations will be accessible.

5. City Hall is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on One Dr. Carlton B. Goodlett Place.

6. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: sotf@sfgov.org

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from the Task Force or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: www.sfgov.org/sunshine

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: www.sfgov.org/mental_health. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

Lobbyist Registration and Reporting Requirements

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics



SAN FRANCISCO MENTAL HEALTH BOARD

MAYOR
EDWIN LEE

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www.sfgov.org/mental_health

MENTAL HEALTH BOARD

May 8, 2013

Attachment A

PROPOSED RESOLUTION (MHB- 2013-XX): THAT THE MENTAL HEALTH BOARD URGES THE MAYOR TO WITHDRAW HIS REQUEST TO CUT THE DEPARTMENT OF PUBLIC HEALTH'S FUNDING.

WHEREAS, the mayor of San Francisco has asked the Department of Public Health (DPH) to cut its budget this year by 20% across the board which will adversely impact services vital for community mental health and well being, and;

WHEREAS, the costs to the community of untreated mental illness are tragic including increased emergency room visits and costs, domestic abuse, rise in crime, school violence, substance abuse, homelessness and suicide, and;

WHEREAS, city and state revenues have actually increased beyond projections, and;

WHEREAS, many other city departments are not being asked to make these budget cuts, and;

WHEREAS, the Mental Health Board believes that the City has a moral or ethical duty to care for those people who are ill, suffering, in trouble, and in need; and,

WHEREAS, the success of Community Behavioral Health programs have shown that with adequate and proper treatment, people can recover, and break the destructive cycle linked to mental illness and substance abuse; and,

BE IT RESOLVED that the Mental Health Board of San Francisco urges the Mayor to withdraw his request to cut the Department of Public Health's funding.

SAN FRANCISCO MENTAL HEALTH BOARD



Edwin Lee
Mayor

1380 Howard Street, 2nd Floor
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
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Unadopted Minutes

Mental Health Board

Wednesday, May 8, 2013

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

San Francisco, CA

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BOARD MEMBERS PRESENT: David Elliott Lewis, Ph D, Co Chair; Ellis Joseph, MBA, Co Chair; Virginia S. Lewis, MA, LCSW, Secretary; Terezia "Terry" Bohrer, RN, MSW, CLNC; Melody Daniel, MFT; Kara Chien, JD; Marlene Flores; Sgt. Kelly Kruger; Alyssa Landy, MA; Lena Miller, MSW; Terence Patterson, EdD, ABPP; and Alphonse Vinh, MS.

BOARD MEMBERS ON LEAVE: Wendy James, Vice Chair

BOARD MEMBERS ABSENT: Errol Wishom.

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jo Robinson, Director of Community Behavioral Health Services (CBHS); Charles Morimoto, Assistant to the Director of Health; Greg Wagner, Chief Operating Officer for the Department of Public Health; Stephanie Felder, Director of Comprehensive Crisis Services for CBHS; David Pine, MD, Mobile Crisis; and three members of the public.

CALL TO ORDER

Dr. David Elliott Lewis called the meeting of the Mental Health Board to order at 6:45 PM.

Just a few hours ago a press release from the California Senate announced that President pro Tem Darrell Steinberg had called for more funding for mental health for prompt access to mental health services for people and families in need.

Ms. Flores was sick and unable to introduce herself at her first board meeting on 4/10/2013. Tonight, she introduced herself saying that 20 years ago she immigrated to San Francisco from Bolivia. She has a college bound son with bipolar disorder. Her son is married and has a daughter. She has business administrative skills and currently works with young people.

ROLL CALL

Ms. Brooke called the roll.

AGENDA CHANGES

There were no changes to the agenda.

ITEM 1.0 DIRECTOR'S REPORT

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

Please see the attached April 2013 Director's report.

Ms. Robinson was not able to attend the meeting so Ms. Brooke highlighted the following items included in the May Director's report.

San Francisco State University will be hosting a Suicide Prevention Regional Conference on October 18, 2013.

There was bipartisan support in the California Senate for three high profile mental health bills: SB 364, SB 585 and SB 664, respectively.

All SFDPH staff are required to complete the 2013 Annual Privacy Training by June 30, 2013.

Monthly Director's Report **May 2013**

1. SF ANSA

We are pleased to announce we are re-instituting the SF ANSA (Adult Strength and Needs Assessment) work group. The aim of the group is to share information and create a collaborative framework around the use of the ANSA. We ask providers to designate one (or more) representative to attend the monthly web or phone conferences. During the meetings, providers will have the opportunity to discuss ANSA reports and ask any questions or provide any input related to ANSA. We hope to launch the conference calls by May 2013. Providers please contact Rose Philipps by email rose.philipps@sfdph.org or phone at 415-255-3799 for more information.

2. SFSU's Suicide Prevention Regional Conference - October 18, 2013

San Francisco State University will be hosting a Suicide Prevention Regional Conference on October 18, 2013.

(See attachment 1).

3. Three High Profile Mental Health Bills Pass Their First Hearing in Senate Health Committee

Three Senate measures dealing with controversial mental health issues were voted out of the Senate Health Committee on Wednesday. SB 364, Senate President pro Tem Darrell Steinberg's measure to amend the Lanterman-Petris-Short Act related to involuntary "5150" holds, passed with bipartisan support. A helpful description of the various provisions in the bill can be found in the Senate Health Committee Analysis. As the bill moves next to Judiciary Committee, Senator Steinberg will be making clarifying amendments to SB 364, including an amendment CMHDA requested to reword statements in the advisements given to clients when detained that, as currently worded in the bill, imply clients will be guaranteed a choice of mental health facility and provider. Once these amendments are made, CMHDA will support the bill. Additionally, Senator Steinberg's SB 585 also received bipartisan support by the Committee, which clarifies that counties may use Prop. 63 and other county mental health funds to provide mental health services to Laura's Law participants. CMHDA supports SB 585. Finally, Senator Leland Yee's SB 664 received support from Democrats on the Committee, but the Republican Senators on the Committee voted against the measure. SB 664 would permit counties implementing Laura's Law to cap the number of participants in the program, and delete the requirements in existing law that Boards of Supervisors authorize each county's implementation of the pilot project, and make a finding that no voluntary mental health service would be reduced as a result. CMHDA's position on the bill is "Oppose Unless Amended" due to significant concerns about removing Boards of Supervisors' role in authorizing implementation of Laura's Law. CSAC has taken an Oppose position on the bill. CMHDA and other mental health advocates will be collaborating on efforts to raise concerns with the bill as it moves forward through the legislative process. (CMHDA Contact: Kirsten Barlow)

4. Transition of Healthy Families Program: Gaps Regarding Treatment of Autistic Disorders

The state's phased-in transition of Healthy Families program beneficiaries to Medi-Cal has progressed relatively well through Phase Three. However, one controversial issue that has emerged as a problem for the Department of Health Care Services (DHCS) is an apparent gap in coverage for certain children with the diagnosis of Autistic Disorder. Under the Healthy Families program, treatment interventions for this diagnostic category were covered by the contracted health plans. Under the Medi-Cal program, Pervasive Development Disorders (Rett's Disorder, Childhood Disintegrative Disorder, Asperger's Disorder, and Pervasive Developmental Disorder, NOS) are included diagnoses under the Medi-Cal Specialty Mental Health program, contingent upon meeting medical and service necessity criteria. However, Autistic Disorder generally is an excluded diagnosis. Children with a diagnosis of Autism -- absent an additional included mental health diagnosis -- are not eligible for Medi-Cal covered services by county mental health plans. Further, Applied Behavioral Analysis (ABA), an evidence-based practice in the treatment of autistic disorder, is not a specified covered service for MHPs. Mental health plans serve children with a co-occurring diagnosis of Autistic Disorder with an array of Medi-Cal covered mental health services addressing the primary included mental health diagnosis, but provision of ABA is not customary or required. Consequently, there now are some children with the diagnosis of Autistic Disorder who do not have access to previously covered services. Clarification from DHCS confirms that mental health plans are not the designated provider for the treatment of Autism, and that ABA is not a specified service. Regional Centers have responsibility for the treatment of Autistic Disorder with required specialty services, but specific criterion for service must be met and not all children with this diagnosis meet them. This gap in coverage and how or whether to address it is being discussed by multiple state

agencies, including DHCS, the California Health and Human Services Agency, and the Department of Developmental Services. (CMHDA Contact: Suzanne Tavano)

5. Compliance Training

It's time to take your Annual Compliance Training (2013) for the San Francisco Department of Public Health. DPH is committed to promoting a strong compliance culture and encourages all DPH employees, contractors, and agents to conduct themselves with the highest legal and ethical standards. To that end, it is every individual's responsibility to be aware of key compliance issues that impact their jobs daily. As such, mandatory compliance trainings are provided to educate employees, contractors, and agents on important compliance laws and policies, including DPH Code of Conduct. We are required by state/federal law and DPH policy to regularly deliver compliance training. Training is provided through DPH on-line training modules. Please see the step-by-step instructions provided below on how to register and access the web-based training modules.

Please note:

A. The following training is **mandatory** and required of all DPH staff, contractors and agents who do business with or on behalf of the Department of Public Health. **DEADLINE: June 30, 2013**

B. The following courses are open to DPH employees and contractors who are not covered by HealthStream or Halogen. All UCSF at SFGH, LHH and COPC employees must take HealthStream courses.

C. **Program supervisors/managers:** please print and post copy of this presentation for any staff/interns who don't have access to a computer.

TO REGISTER:

- 1) Go to the DPH internet (public site) <http://www.sfdph.org>
- 2) Midway down, on the left side of your screen, you will see:

Education and Training

Training is integral to all aspects of public health practice. The San Francisco Department of Public Health provides and sponsors trainings and continuing education for staff, community partners, and the public. The Community Programs Training Unit and the Health Education Training Center now offer online registration.

LEARN MORE

- 3) Click on "LEARN MORE" this will take you to a new window
- 4) Click on the **Online Classrooms** icon, this will take you to a new window with the programs offering online classrooms.
- 5) Select **DPH Compliance Office**
- 6) Select one of the three courses:
#900: General: Non-Clinical Staff
#901: Clinical Staff
#902: Management

7) Login and follow the prompts from there.

Create an Account:

✎ If you do not have an account, please select one of the following to register:

-DPH Employees

-Non-DPH Users (Contractors, etc.)

***Non-DPH Users, please be sure to provide your full name, phone number, and e-mail address when you register, to ensure that your completion of training is recorded correctly.**

8) Once you have completed this section, it will take you back to your selected training. Follow the prompts above.

6. The 2013 Annual Privacy Training

The 2013 Annual Privacy Training is now posted in the On-line Classrooms on the DPH Public Website (www.sfdph.org).

All SFDPH staff are required to complete this training when hired, and annually thereafter. Please review the training slides, take the associated quiz, print your certificate of completion, and give this to your supervision before June 30, 2013.

To access the training, go to the Education and Training box on the main page of SFDPH.org, and click "Learn More"

In the On-line Event Registration System, select On-line Classrooms.

Select "DPH Privacy Board"

Select "Enter Classroom" for the Annual HIPPA Review Privacy and Security Training Module (2013).

Follow instructions at the bottom of the Login page to create a user name and password, or to register if you don't know your user name or password- click on DPH Employee or Non-DPH employee as appropriate.

Please complete all the requested information (name, email address etc).

Once you are registered, review all the slides before taking the quiz. A personalized certificate will be issued when you successfully pass the quiz- give this to you supervisor (if you lose it, you can go back into the system and print another copy).

Every supervisor needs to ensure that all supervised employees have completed this training when hired and every year.

DPH -Contract agencies may use this training to satisfy their annual training requirement, and copies of the certificate for each employee should be made available to DPH Business Office and Contract Compliance staff during audits.

DPH Staff who use Healthstream or Halogen should access this training through their usual process.

For Programs that do the training in a group, each staff person should still register through the on-line system to complete the quiz and receive a certificate of completion.

7. E-Prescribing

E-Prescribing for CBHS clients' prescriptions began almost three years ago when our system changed from an outdated phone, fax and paper-based methods to electronic transmission through Infoscriber. In April 2013, 140 prescribers using Infoscriber sent 10,254 prescriptions to pharmacies throughout San Francisco!

E-prescribing improves medication safety by providing drug-drug and drug-allergy checks as well as medication history and drug information for prescribers at the time medications are ordered. The electronic transmission improves accuracy and efficiency by eliminating miscommunications associated with phone and handwritten prescriptions. For clients, only one trip is needed to the pharmacy to pick up a prescription rather than one needed to drop it off and another to pick up.

E-prescribing improves our clients' coordination of care. The client's medication list and allergies is accessible to all CBHS providers providing care to the client. In Avatar, clinicians can view their clients' Medications and Allergies in:

1. Client View "Current Medications" Widget (top right corner)
2. "Med List and Allergies" Report
3. "Medication History" Report

In contrast to paper or phone prescription, e-prescribing provides CBHS with system-wide medication use information. The utilization data is already helping us to better address drug recalls, new FDA drug warnings and to form strategies for optimizing medication use and improving safety for CBHS clients.

Interested in learning more about e-prescribing?

A good reference is the "Clinician's Guide to e-Prescribing 2011" by the AMA in collaboration with other stakeholders (link: <http://www.ama-assn.org/resources/doc/hit/clinicians-guide-erx.pdf>) CBHS specific procedures are found in the CBHS Electronic Prescribing Policy 6.00-02.

8. Jail Psychiatric Services Intern Training Program

The Jail Psychiatric Services Intern Program offers a 10-month internship for any student pursuing a graduate degree in the field of mental health with an interest in forensics. Each year JPS receives over 120 intern applications and the program accepts between 8 to 10 interns that are assigned to either the Jail Psychiatric Service General Tract or the Jail Aftercare Tract. The interns are immersed in a 6-week intensive training with JPS before they go on to conduct individual and group therapy with the clients. The focus of the treatment is to provide the chronically mentally ill with evidenced-based individual and group therapy utilizing a supportive and recovery model paradigm. Students are

encouraged to understand the clients from a biopsychosocial perspective in addition to acknowledging the stressors associated with incarceration.

The JPS Intern Program provides the students with weekly individual clinical and group supervision as well as a two-hour weekly didactic seminar and an administrative meeting. The overarching training goals and objectives are fourfold; firstly, to provide the interns with a clinical experience that expands their therapeutic skills with an emphasis on developing the therapeutic alliance, the use of empathy and active listening. Secondly, to foster the development of rigorous diagnostic skills that are an essential precursor for determining an appropriate treatment plan and re-entry disposition. Thirdly, to encourage interns to examine transference and counter-transference issues with an emphasis on the cultural and ethnic concerns that may impact the client-therapist relationship. Lastly, to enhance the interns ability to use theoretical models and clinical research as an internal organizing framework to better understand the client and implement the appropriate treatment.

9. Katie A. Implementation

The San Francisco Human Services Agency-Family and Children's Services (FCS) and the Department of Public Health-Community Behavioral Health Services (CBHS) is partnering together to develop a wellness plan to serve the needs of foster care youth who are members of the Katie A. subclass. Under the Katie A. litigation, plaintiffs filed a class action lawsuit in 2002 alleging violations of several federal laws including Medicaid. The suit sought to improve the provision of mental health and supportive services for children and youth in, or at imminent risk of placement in, foster care in California. In 2011, a statewide settlement agreement was approved which seeks to accomplish systemic change. Through this agreement and its accompanying requirements, HSA-FCS and DPH-CBHS will develop comprehensive mechanisms to systemically deliver the highest quality, effective trauma informed, resiliency based and attachment oriented services to the at risk and foster care population.

HSA and CBHS/CYF have jointly contracted with CIMH to provide facilitation and planning services and support the agencies, family, youth and service providers to develop a shared plan meeting the Kate A. requirements and utilizing all available resources. Discussion and action items will focus on vision, principles and practices in order to complete the DHCS required Readiness Assessment Plan and design a Project Plan to complete the Service Delivery Plan for Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS).

Specifically we will:

- Development of shared principles and practices to meet the Katie A. mandate
- Development of a shared vision for the development of effective treatment models designed to serve Foster Care Youth's well-being, using EPSDT to support these services when applicable
- Establishment of program and service priorities and implementation plan

- Adoption of standards for service and evidence and practice-based services that meet the needs of foster care youth, their families and the communities, and when appropriate leverage EPSDT funding.
- Identification of issues to be addressed and documented within the Joint Agency Memorandum of Understanding (e.g. goals, roles, responsibilities, risk sharing and resource commitments).
- Completion of DHCS Required Readiness Assessment and Project Plan to complete to complete the Service Delivery Plan for Intensive Care Coordination (ICC) and Intensive Home Based Services (IHBS)

10. Reducing Teen Drinking

Underage drinking has numerous negative consequences, which have been researched and reported in depth. Starting at age 11, for each year that a young person delays drinking alcoholic beverages they reduce by about 8% their chance of developing severe alcohol problems as an adult. Individuals who don't drink until after age 21 rarely develop serious alcohol problems. However, there has been less reporting of proven effective methods to delay underage drinking. One efficient method is school based social norm campaigns, such as implemented by Youth Leadership Institute in conjunction with CBHS at Thurgood Marshall and George Washington High Schools.

Our goal is an increase in student perceptions that most students choose not to drink alcohol, and that it is perfectly acceptable among peers NOT to drink.

A. Progress Made

Youth Participants at Thurgood Marshall and George Washington High School have built their individual and collective leadership skills by participating in ongoing development. Youth received training including data analysis to interpret school wide surveys, using data to inform message development, and campaign implementation. The data analysis training helped youth identify key areas they wanted to highlight in their positive social norms campaigns. During this quarter, youth have made the transition from the research phase and assessment phase to implementation. Youth from both sites engaged in a creative process to bring their messages to life through media creation. Each site has created three movie size posters that represent some of their most startling "actual norms."

TMAHS Findings include:

- 87.8% of TMAHS students never or hardly ever drink (in the past 12 months).
- 79% of TMAHS students have not had a drink in the last 30 days.
- Only 5% of students (combined data) engage in binge drinking (5 or more drinks) when they do drink.

GWHS Findings include:

- 85.6% of GWHS students never or hardly ever drink (in the past 12 months)
- 79.5% of GWHS have not had a drink in the past 30 days.
- 83.1% of students (combined data) prefer not to drink alcohol at parties.

Through a combination of statistics, imagery, design, and humor youth have created a marketing campaign for their schools and community. Working together with school administrators and local community retailers youth from each site have secured space to display their media in their communities' most trafficked areas. We have researched opportunities to advertise this positive social norms campaign along with our counter ad campaign through Titan Advertising Company. We will submit our final media campaign designs to Titan who will await approval from the MTA. We hope to launch the media campaigns through media advocacy and MUNI interior bus advertising spaces on routes frequented by youth and families.

In addition, QUUAD (Thurgood Marshall Academic High School) has opted to further expand their media creation by engaging in the development of a PSA. This two-minute video shows the major flaws and consequences of practicing perceived social norms versus actual norms. The PSA goes on to explain the importance of youth/adult communication around these issues. Youth are the stars, producers, and editors of all of the media they have created.

B. Successes

Youth at GWHS and TMAHS have strengthened their existing bonds within their respective groups and across programs. Youth have also deepened their understanding of environmental factors that contribute to higher alcohol consumption of certain populations and communities through an intensive two-day retreat. Each group has continued to represent their efforts to reduce underage drinking at both school and community events. Youth created 8 different posters to support their efforts. Youth have secured local as well as potential citywide venues to display their media in an effort to reach the largest number of their target audience.

11. Transitional Care in Psychiatry Project

Half of hospital-related medication errors and 20% of adverse drug events are attributed to medication changes and poor communication at interfaces of care. Within the SF Department of Public Health, clients with psychiatric illness are at particularly high risk for medication errors during care transitions due to a lack of integration of electronic records for these clients, and their own difficulties in communicating about their care. In a 2012 survey, psychiatric prescribers within DPH reported having complete and accurate medication history information for clients who transfer to their care less than 50% of the time.

CBHS has begun a pilot program to provide transitional care for hospitalized psychiatric patients. In the initial pilot, an outpatient CBHS clinical pharmacist began meeting with the inpatient teams on the psychiatric units at SFGH during their patient care rounds to ensure access to outpatient medication records. This has resulted in increased access to and use of the outpatient electronic record for CBHS clients and improvements in facilitating contact between inpatient and outpatient providers. It has also resulted in plans for a future program to provide documentation within the outpatient record of any medication changes that occur during hospitalization and administration of long-acting injectable medications. This pilot program has been acknowledged as a best practice by

APS Healthcare, which is CBHS's External Quality Review Organization (EQRO), and will be highlighted in a statewide webinar by EQRO on June 11, 2013. For more information, contact Jeanette Cavano, Pharm.D., Clinical Pharmacist, at Jeanette.Cavano@sfdph.org.

Past issues of the CBHS Monthly Director's Report are available at:

<http://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSDirRpts.asp>

To receive this Monthly Report via e-mail, please e-mail reanna.albert@sfdph.org

1.2 Public Comment

No public comment.

ITEM 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Updates

No updates.

2.2 Public comment

No public comment.

ITEM 3.0 ACTION ITEMS

Dr. David Elliott Lewis stated that in addition to approving the April 2013 minutes, the board will be voting on a Budget Resolution proposed by the Executive Committee. To help the board and the public understand more about the budget, **Greg Wagner**, the Chief Operating Officer for the Department of Public Health will give a brief overview of the budget issues. Then we will call for public comment before voting.

Greg Wagner said San Francisco City's General Fund has improved marginally but there are still projected imbalances of \$130M in the FY 2013-2014 and \$263M in FY 2014-2015 budgets, respectively. For the FY 2012-2013 there is already a \$31M deficit that required supplemental appropriation from the General Fund. Since deficits are driven by State and Federal funding, the City General Fund greatly influences Department of Public Health (DPH) programs.

DPH directors have asked the Board of Supervisors for a \$45M supplement to maintain safety net services. DPH's deficits are driven mostly by the imbalance between increasing costs and slowing revenues, the realignment, reduction in federal grants and payments, and reimbursement rate cuts in state skilled nursing.

It is expected to get worse! DPH needs a large increase in the subsidy from the City's General Fund. According to the Five-Year Projection planning, a \$290M subsidy in General Funds is needed.

Over the next few years, DPH hopes to control expenses, to maximize revenues and to lower deficits. To position itself for financial stability in the future and to prevent deterioration of safety-net services, DPH planners need to make some difficult necessary decisions today. For example, making cuts in services and/or programs that do not generate revenue.

DPH has been working with the following deadlines. May 7, 2013 was the second Health Commission budget meeting. Jun 1, 2013 DPH will submit to the Mayor's Office a balanced budget proposal and will attend Board of Supervisor budget hearings.

The proposed 20% cut from the General Fund was DPH's response to the request from the Mayor's Office. The Mayor's Office requested a budget cut of 1.5% -- 25% range from every City department, with exceptions in certain categories in children and maternal health. Although Mayor Ed Lee has been very supportive of public health, DPH still must pull its own weight just like any other non-exempt City department.

Ms. Bohrer asked for a cut comparison between DPH and other non-exempt City departments.

Mr. Wagner explained that the Mayor's Office gave a uniformed request of 1.5% as minimum cut to each City department. Each department's future viability is dependent on sound fiscal discipline.

In order to comply with the Mayor's Office minimum cut percentage, and to maintain financial and operational stability in the future, DPH has to consider more cuts in non-revenue generating programs. Thus the proposed final cuts percentage amounted to about 20% of DPH's budget.

Dr. Patterson asked for clarification on physical health and mental health, since the Obama Healthcare Act has mandatory health parity.

Mr. Wagner said that DPH has to take all care programs into consideration, and the nuance between physical health and mental health is difficult to distinguish per se. DPH also must be ready for the Affordable Care Act (ACA) in 2014, aka the Obama Healthcare Act program.

We want to ensure health parity and that services are coordinated in timely fashion. To achieve that goal, the current focus will be more on how to keep revenues on par with expenses to prevent future cuts. Non-revenue generating programs are slated to cuts. The current Director of DPH is Barbara Garcia, and she envisions parallel and coordinated care for both health systems.

3.1 Public comment

Ms. Michele Schultz is with Mental Health Association, San Francisco, (MHA-SF) and requested a copy of Mr. Wagner handouts.

Dr. David Elliott Lewis stated that the handouts will be incorporated into the meeting minutes, which is publicly available upon the board adoption of the May 2013 minutes.

Ms. Wendy Yu testified that private health insurances tend to be very parsimonious with mental healthcare. She felt her mental healthcare with CBHS is much better than when she had private health insurance when she was working. She suggested replicating San Francisco's mental healthcare system by opening up enrollments to people with private health insurance, so CBHS can

subrogate private health insurances. She felt that commercial health insurances short changed people by focusing on physical health at the expense of mental health care. She believed her proposal would be in alignment with DPH's revenue generating goal.

3.2 PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of April 10, 2013 be approved as submitted.

Unanimously approved

3.3 PROPOSED RESOLUTION (MBH 2013 –XX) That the Mental Health Board Urges the Mayor to Withdraw His Request to Cut the Department of Public Health's Funding.

Resolution was unanimously tabled. The board proposed to have the resolution be re-drafted and discussed at the May 16 Executive Committee and to be added back to the June 12, 2013 Agenda.

ITEM 4.0 PRESENTATION: COMPREHENSIVE CRISIS SERVICES, STEPHANIE FELDMAN, MS, DIRECTOR AND THE "INTERRUPT, PREDICT & ORGANIZE INITIATIVE", CHARLES MORIMOTO, DEPUTY DIRECTOR OF THE DEPARTMENT OF PUBLIC HEALTH

Dr. David Elliott Lewis introduced Stephanie Felder, Director of Comprehensive Crisis Services. The Mental Health Board highlighted her last month because she was given a Women Making History Award by the Board of Supervisors. She has spent over 18 years providing direct crisis services. She will present first, then Charles Morimoto, Assistant to the Director of Health, will present the Mayor's "Interrupt, Predict and Organize" initiative. He has been with the Department of Public Health for many years, working closely with Barbara Garcia for the past decade.

4.1: Presentation: Comprehensive Crisis Services, Stephanie Felder, MS, Director, and the "Interrupt, Predict & Organize Initiative", Charles Morimoto

Comprehensive Crisis Services (CCS): Stephanie Felder and David Pine, MD

CCS is comprised of five different teams: Mobile Crisis, Child Crisis, Crisis Response, Crisis Wrap, and Multi-Systemic Therapy (MST) and provides a 24-hour, multilingual, crisis intervention and short-term stabilization program for families and children who are experiencing emotional distress related to family violence, physical or emotional illness, school truancy, behavioral problems and other crises. When a troubled family member or concerned observer contacts the program, the family may either arrange to come to the clinic or a crisis team may travel to the home, school or other San Francisco location to evaluate the problem. Evaluation includes assessment for inpatient hospitalization.

CCS provides Dialectical Behavior Therapy (DBT) (no fee) for youth and their families. DBT is for youth experiencing chronic suicidal feelings, self-injurious behavior, substance use and truancy. DBT is offered for adolescents between the ages 13-17 1/2 (at the initiation of treatment). DBT is for those who currently have suicidal ideation; have a recent suicide attempt/gesture; have a diagnosis of borderline personality disorder or must have three borderline personality features that have persisted for at least one-year (e.g. para-suicidal behavior, high-risk sexual practices.

substance abuse, truancy, instigating fights, or other aggressive acts); and both the youth and a significant caretaker must be willing to participate in the treatment program.

Ms. Felder introduced Dr. David Pine from the Mobil Crisis Team.

Besides operating on a 24/7 schedule on crisis evaluation and intervention, CCS has a core of 10-12 staffers along with advanced graduate students in psychology and psychiatric social work. Staffers can converse in Spanish, Cantonese, Tagalog, Russian, Vietnamese and American Sign Language (ASL). CCS is the only agency, if necessary, that can do a 5150 (72 hour hospital hold) on children.

In the Child Crisis program, children under 12 years of age are placed out-of county. Langley Porter of University California San Francisco can accept children over 12 years of age. Psychiatric beds are scarce for all ages. Having a partnership with Edgewood has allowed for 12-13 additional psychiatric beds for children.

Other programs of CCS provide schools with group services and with medication support. They also offer collaborative coordinated psychiatric care with other community programs. CCS does outreach at homeless facilities to support families. CCS does grief counseling, cognitive behavioral therapy, debriefing care in the communities and in work places that were impacted by violent, suicides and fires.

Ms. Bohrer inquired the impact of budget cuts.

Ms. Felder explained that CCS remains financially solvent through multiple funding resources. Also just as Greg Wagner mentioned earlier, CCS is in the exempted category of maternal and child health services.

Dr. Pine said that his Mobile Crisis team was relocated into the same location as CCS in December 2011. Although housed in the same location, his agency operates from Monday to Friday from 8:30 AM – 11 PM and 12 PM – 8 PM on Saturdays. Mobile Crisis responds to referrals including self-referrals.

Last year the agency responded to 1,900 calls for care and 600 field visits. In the fiscal year 2011 — 2012, 40% of field visits resulted in 5150's. The agency has a strong working relationship with the Dore Urgent Care Center (DUCC) and other psychiatric care agencies. A goal of Mobile Crisis is pre-hospitalization intervention to prevent a full-blown acute psychiatric emergency.

Ms. Bohrer wondered if Mobile Crisis responds to all critical incidents.

Mr. Morimoto stated that, according to the disaster protocols, usually the Human Services Agency (HSA) or the Red Cross will contact the San Francisco Disaster Team, which activates a group of civil service employees to respond to critical incidents.

Ms. Virginia Lewis wanted to know the funding sources for Mobile Crisis.

Dr. Pine said revenues come from Medi-Cal, Healthy Families, Healthy Kids, private insurances and sliding scale payments.

Dr. Patterson asked if Mobile Crisis responds to an apartment fire.

Mr. Morimoto said that usually such incidents would require HSA to activate a City and County of San Francisco's Disaster Responding Team.

Dr. David Elliott Lewis wanted to know about response to community violence perpetrated by gangs.

Ms. Felder said the San Francisco Police Department (SFPD) will directly request immediate response, and CCS works with Community Response Network (CRN) to de-escalate retaliation.

Sgt Kruger asked for clarification on the placement program at Edgewood.

Ms. Felder said an initial 5150 assessment is required before a diversion placement is made. She provided an example of a 16 year old without any active follow-through plans on suicide ideation but showed some attention getting evidence of superficial cuts on arms. This person would benefit more from a diversion bed than hospitalization.

Dr. David Elliott Lewis said Edgewood for children is akin to DUCS for adults.

Ms. Daniel wanted to know how the public can access CCS services.

Ms. Felder said just call 415-937-3800.

Mayor's "Interrupt, Predict & Organize" Initiative: Charles. Morimoto

Mr. Morimoto said that the Interrupt, Predict & Organize (IPO) Initiative was a work in progress with the initial-stage of the final plan completed on April 30, 2013. In the next few weeks, the final plan will be sent to City departments for comments, and CBHS had great influence on the IPO.

For example, in a homicide incident, there is a multi-response from SFPD, to hospitals to mobilization of crisis recovery. He attended and worked on, so far, 50 homicides this year. San Francisco's system of care has complex post traumatic stress disorder (PTSD) trainings and Ken Epstein, Director for the Children, Youth and Families' System of Care, is considering trauma focused trainings.

Ms. Chien was very impressed with how the IPO is being built and strengthened. She hoped the IPO will be able to respond to larger disasters.

Mr. Morimoto said the IPO is just a response to street violence. He is developing disaster trainings, although he has done trauma, psychological first aid and disaster first aid training in 2012.

Dr. David Elliott Lewis asked about holding perpetrators accountable in the no-snitching culture.

Mr. Morimoto said they work with SFPD. He gave an example of community violence where a victim's mother must maintain self composure and sit in the same room with perpetrator's mother. He has seen the wonder of resiliency and perseverance.

His power point presentation is at the end of the minutes

4.2 Public Comment

Ms Yu asked about the Metropolitan Transportation Agency (MTA) involvement in public safety, since she has seen so much vandalism. She also wanted to know about peer response care and peer-support services.

Ms Felder stated there were discussions about peer support for individuals.

Ms. Yu stated that it is great to have a team, but not so great when the team is inaccessible. She pointed out that in April 2013; there was a person who was stabbed 50 times.

Dr. Pine said that Mobile Crises will respond to field crises.

ITEM 5.0 REPORTS

For discussion

5.1 Report from the Executive Director of the Mental Health Board.

Ms. Brooke stated the following:

1. May 22nd, 2013 at Holiday Inn in San Francisco is MANAGING STRESS – MINIMIZING THE IMPACT OF VIOLENCE ON YOUTH
2. May 24th, 2013 at the San Francisco Public Library, Koret Theater is the 2013 Trauma Training Series – Psychophysiology of Trauma
3. May 30th, 2013 at 1800 Oakdale Ave, 1st Floor in the Alex Pitcher Community Room is a Job/Career Fair
4. Vacation Thursday May 30th – Monday June 10th

5.2 Report from the Chair of the Mental Health Board and the Executive Committee.

The next Executive Committee meeting is next Thursday, May 16, 2013 at 6:30 pm at 1380 Howard Street, Room 515. All board members are welcome to attend the meeting as well as members of the public.

5.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

None mentioned.

5.4 Report by members of the Board on their activities on behalf of the Board.

Dr. David Elliott Lewis along with several Physicians Organization Committee (POC) members just met with the director of the Mayor's Office, Ken Rich who acknowledged that Sutter Foundation (or CPMC) will move forward with their capital improvement projects which have no definitive commitment to allocation of non-privately insured psychiatric beds.

Ms. Bohrer has been running a policy group and encouraged everyone to join her policy group at noon on every Wednesday at MHA-SF.

Ms. Miller said she was very encouraged for the San Francisco southeast sector as a result of her District 10 Trauma Report. City supervisors can no longer ignore the sector's plight and must respond and deploy financial resources for more services and programs.

5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

Ms. Miller just attended the 2013 California Local Mental Health Boards and Commissions (CALMHB/C) meeting in Ontario, California as a representative from the northern region of California. She encouraged the board to invite Cary Martin to give a presentation on the mental health component in the Obama Healthcare Act. She would like the board to follow other California counties in reviewing program contracts before doing any site visit or program review.

5.6 Public comment.

Wendy Yu suggested making SF's mental health system be open for private subscription.

ITEM 6.0 PUBLIC COMMENT

No public comment.

ADJOURNMENT

Meeting adjourned at 8:45 PM.

Mr. Wagner's power point

Mr. Morimoto's power point

DEPARTMENT OF PUBLIC HEALTH

FY 13-14 & 14-15 BUDGET

April 23, 2013

Department of Public Health Financial Position

- **DPH is facing very significant financial challenges**
 - City General Fund situation has improved, but still facing \$129M and \$263M deficits for FY 13-14 and FY 14-15, respectively
 - \$31M current year deficit required General Fund supplemental appropriation
 - Large additional draw on General Fund projected in the future
 - DPH must prepare itself to be financially stable in changing health care world

- **Causes of Financial Challenges**
 - 1. Historical "Structural" Issue
 - 2. Rapid cost inflation
 - 3. State and Federal reductions
 - 4. Revenues not keeping pace with costs

What is Causing Deficits at DPH?

3

1. Historical "Structural" Deficit

"Structural" Deficit

- ☐ DPH has historically been under-budgeted for salaries and fringe benefits
- ☐ In the past, this was less of a problem because DPH was able to cover some or most of its overspending with excess revenues
- ☐ But the imbalance has grown with salary and benefit cost increases
- ☐ As a result the General Fund has borne more of these costs

History of DPH Structural Deficit (\$ Millions)

FY 2006-07	FY 2007-08	FY 2008-09	FY 2009-10	FY 2010-11	FY 2011-12
\$ 23.30	\$ 16.86	\$ 14.15	\$ 20.81	\$ 29.49	\$ 41.25

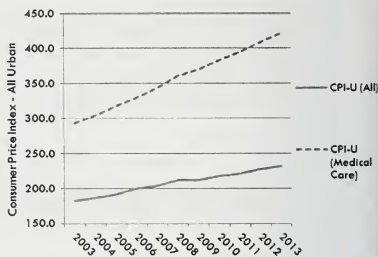
What is Causing Deficits at DPH?

4

2. Rapid Cost Inflation

- Like other healthcare systems, costs are growing faster than general inflation
- ~\$50 Million per year growth in personnel and other costs (pharmacy, medical supplies, etc) just to maintain existing service levels (5-Year Financial Plan)

Medical Inflation has Significantly Outpaced General Inflation



What is Causing Deficits at DPH?

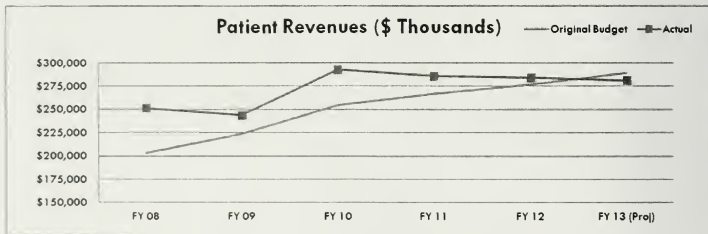
3. State and Federal Reductions

- ☐ State Skilled Nursing Facility rate cut (\$30+M)
- ☐ Failure to Approve Mental Health Reimbursement Program (\$16M)
- ☐ Managed Care rates for Seniors and Persons with Disabilities (\$19M)
- ☐ Federal Grants – HIV, TB, etc
- ☐ Realignment?

What is Causing Deficits at DPH?

4. Patient Revenues Not Keeping Pace with Costs

- ☐ Expiration of federally enhanced payments
- ☐ Transition to Managed Care Reimbursement Model
- ☐ More aggressive revenue budgets to minimize service reductions, but limits "upside" available to cover costs



5-Year Projection

Table 26: Base Case Projections for the Department of Public Health (DPH) FY 2014-18 (\$ in millions)

	FY 13-14	FY 14-15	FY 15-16	FY 16-17	FY 17-18
SOURCES Increase / (Decrease)					
DPH Revenues	10.8	17.0	24.7	23.8	23.7
USES Decrease / (Increase)					
Salaries and Benefits	(44.6)	(35.6)	(28.6)	(30.6)	(32.3)
SFGH Rebuild on-going and one-time FF&E costs	(40.0)	(25.0)	15.0	23.8	(1.3)
Annualization of Anticipated Supplemental	(37.5)	(2.2)	(2.4)	(2.5)	(2.7)
Inflation on non-personnel costs and grants to non-profits	(6.7)	(20.7)	(20.7)	(19.9)	(19.8)
Annualize State Supplemental	(3.0)				
Health Care Reform, Regulatory and Other	(21.0)	(3.1)	(5.2)	(8.2)	(16.3)
TOTAL CHANGES TO USES	(152.8)	(86.6)	(41.8)	(37.5)	(72.5)
Projected Growth (Shortfall) vs. Prior Year	(141.9)	(69.7)	(17.1)	(13.7)	(48.8)
Cumulative Growth	(141.9)	(211.6)	(228.7)	(242.4)	(291.2)
Portion of General Fund Growth Assumed for DPH	85.0	22.4	18.6	14.3	19.4
Remaining Surplus (Shortfall) vs. Prior Year	(57.0)	(47.3)	1.5	0.6	(29.4)
Cumulative Projected Surplus (Shortfall)	(57.0)	(104.2)	(102.7)	(102.1)	(131.5)

5-Year Projection

Absent changes, DPH will require an increasing share of the General Fund:

- If no action is taken, \$291M additional General Fund need in five years
- Even after accounting for growth in the economy, DPH would need \$131M more than its proportional share of that growth
- DPH goal of reducing GF growth by \$100M over four years (compared to 5-Year Financial Plan projections)

Take-Aways:

- DPH can position itself to be successful and financially stable in the future
- But that requires making some difficult decisions today
- If we don't take action, we risk continued deficits and deterioration of safety net services

FY 13-14 and FY 14-15 Proposed Budget

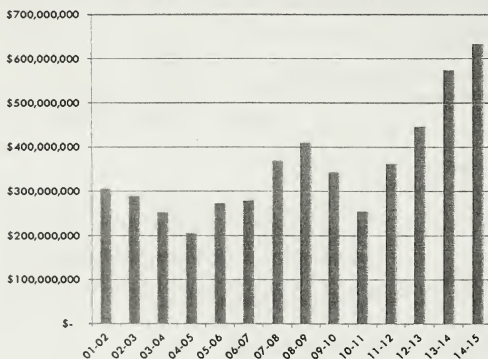
Increase/(Decrease) in DHP General Fund Support Compared to FY 12-13 (\$ Millions)	13-14 Impact	14-15 Impact	Cumulative Impact
Baseline Growth*			
Salaries and Benefits	44.6	35.6	80.2
SFGH Furniture, Fixtures and Equipment	40.0	25	65.0
Structural Salary Deficit	37.6	2.2	39.8
Subtotal	122.2	62.8	185.0
Budget Proposals			
Non-Personnel Cost Inflation	7.5	8.6	16.1
Regulatory Costs	11.2	(1.1)	10.1
Revenue	(4.4)	(1.9)	(6.2)
Reductions	(13.6)	(12.1)	(25.8)
Emerging Needs	5.2	3.0	8.3
Subtotal	6.0	(3.5)	2.4
Total General Fund Support Increase (Decrease)	128.2	59.3	187.4

*Projections from City and County of San Francisco, Proposed Five-Year Financial Plan, Fiscal Years 2013-14 through 2017-18

FY 13-14 and FY 14-15 Proposed Budget

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DPH General Fund Subsidy by Fiscal Year
(with projections for FY 13-14 and 14-15 budgets)



FY 13-14 and FY 14-15 Proposed Budget

Proposed FTE Changes by Category

	FY 13-14	FY 14-15
Structural	66.0	87.9
Health Reform Preparedness	15.2	29.0
Other	1.5	14.3
Total FTE Change	82.7	131.2

FY 13-14 and FY 14-15 Proposed Budget

Other Budget Issues:

- Funding is assumed for new SFGH FF&E (\$105M over two years)
- Working with Controller's Office to on lease financing
- CBO COLA from FY12-13 remains in budget but does not increase
- HIV/AIDS funding unchanged from last year's adopted FY 13-14 budget
 - Mayor's Office restored 50% of prior federal grant reductions to Ryan White and HIV Prevention.

Timeline

- May 7 – Second Health Commission Budget Hearing
- June 1 – Mayor's Balanced Budget Submission
- June – Board of Supervisors Budget (BOS) Hearings
- June 28 – BOS Budget and Finance Committee approves amended budget
- Mid-July – Final BOS approval of Budget

Budgetary Back-Up Detail: CBO Across the Board Reductions. Agencies with no reductions are not included. If an agency has any reduction, then the entire agency is included in the detail as of 08.02.12													
Section	Agency	Modality	Program/Provider	Total FY 12-13 Budget Less One-Time Funding	Total Non-Matched General Fund Monies	FY12-14 Non-Matched General Fund Reductions (10 mos.)	FY14-15 Non-Matched General Fund Reductions (2 mos.)	Total General Fund Reductions	% General Fund Reduction of total Agency Funding	Estimated UDC Reduction Based on % of Reduction to Budgeted UDC	Total UDC	Total UDC (Note 15 Not even converted to hours from minutes)	
SA Adult	Asian & Pacific Islander Wellness Center	Wellness Promotion & Prevention	Special Project: Trans Females who Have Sex with Men (SP TFSA)	250,000									
SA Adult	Asian & Pacific Islander Wellness Center	Prevention	Heart Education Risk Reduction (HERA)	152,865	152,865	31,847	6,369	38,216	25%	144	570	2,055	
SA Adult	Asian & Pacific Islander Wellness Center Total			402,865	152,865	31,847	6,369	38,216	9%	144	570	2,055	
SA Adult	Asian American Recovery Svs	Fiscal Intermediary	Payment to Board and Case facility operators, out-of-county foster care providers, and misc programmatic payments	10,135,535									
SA Adult	Asian American Recovery Svs	Outpatient	SOC - Project Reconnect	13,860									
SA Adult	Asian American Recovery Svs	Outpatient	SOC - Project Reconnect	1,156									
SA Adult	Asian American Recovery Svs	Outpatient	SOC - Project Reconnect	8,065									
SA Adult	Asian American Recovery Svs	Outpatient	SOC - Adapt MH	164,340	111,338	23,195	4,639	27,833	17%	22	130	1,064	
SA Adult	Asian American Recovery Svs	Outpatient	SOC - Project ADAPT	272,214	247,614	51,401	10,302	61,704	23%	26	115	2,666	
SA Adult	Asian American Recovery Svs	Outpatient	SOC - Low Woodard Counseling Center	278,286	278,286	57,976	11,595	69,572	25%	20	60	2,731	
SA Adult	Asian American Recovery Svs	Prevention	SOC - CORPAA	132,685	132,685	27,643	5,529	33,171	20%	500	2,000	1,302	
SA Adult	Asian American Recovery Svs	Residential Treatment	SOC - Resiliency Therapeutic Community	611,580	518,235	64,779	64,779	129,559	21%	8	36	5,977	
SA Adult	Asian American Recovery Svs	Outpatient	SOC - Project Youth Reconnect	235,761									
C-OPIC	Asian American Recovery Svs	Primary Care	Asian American Recovery Services (TWHC)	40,000	40,000								
C-OPIC	Asian American Recovery Svs	Primary Care	Asian American Recovery Services (Medical Records Clinic)	116,177	116,177								
PLHJ	Asian American Recovery Svs - Total	Fiscal Intermediary	Check Writing Services - Emergency Hotels	2,622,767	1,756,000								
SA Adult	Asian American Recovery Svs - Total			20,852,486	2,190,738	226,556	99,431	325,987	1%	475	2,261	12,780	
SA Adult	Baker Placem, Inc.	Residential Treatment	San Jose Place	622,895	339,995	42,499	42,499	84,999	10%	19	180	5,814	
SA Adult	Baker Placem, Inc.	Residential Treatment	Baker Street House	853,671	164,756	24,349	24,349	48,698	6%	8	148	7,032	
SA Adult	Baker Placem, Inc.	Residential Treatment	Green Street House	1,120,431	319,500	39,308	39,308	78,617	7%	11	150	3,385	
SA Adult	Baker Placem, Inc.	Residential Treatment	Jo Ruffin Place	1,041,104	254,964	35,621	35,621	71,242	7%	14	200	7,632	
SA Adult	Baker Placem, Inc.	Residential Treatment	Robertson Place	764,545	284,937	35,617	35,617	71,234	9%	17	192	6,342	
SA Adult	Baker Placem, Inc.	Supportive Housing	Oakway House	419,085									
SA Adult	Baker Placem, Inc.	Supportive Services in Supportive Housing	ALP (Assisted Independent Living)	1,171,164									
SA Adult	Baker Placem, Inc.	Residential Treatment	COOB	118,670	118,670	14,834	14,834	29,668	25%	-			
SA Adult	Baker Placem, Inc.	Residential Medical Detox	Joe Healy Medical Detox	100,885									
SA Adult	Baker Placem, Inc.	Residential Medical Detox	Joe Healy Medical Detox	3,520,534									
SA Adult	Baker Placem, Inc.	Residential Treatment	Acceptance Place	822,290	622,290	77,786	77,786	155,573	25%	15	60	3,466	
SA Adult	Baker Placem, Inc.	Residential Treatment	Feigelson Place	263,745	-								
PLHJ	Baker Placem, Inc.	Residential	Supportive Living Residential Subsites	720,370	-								
PLHJ	Baker Placem, Inc.	Residential Treatment	Feigelson Place	342,303	-								
PLHJ	Baker Placem, Inc.	Residential	Supportive Living Residential Subsites	10,917	-								
SA Adult	Baker Placem, Inc. - Total			11,852,828	2,185,191	270,444	270,444	540,888	5%	84	1,480	41,340	
SA Adult	Beyenne Hunters Point Foundation	Fiscal Intermediary	Family Monies	365,679									
SA Adult	Beyenne Hunters Point Foundation	Outpatient	Subsidiary	454,031									
SA Adult	Beyenne Hunters Point Foundation	Wellness Promotion & Prevention	PEI school-based services	231,101									
SA Adult	Beyenne Hunters Point Foundation	Outpatient	Ancho Behavioral Health	1,019,346	304,059	63,348	12,069	75,417	7%	45	600	5,905	
SA Adult	Beyenne Hunters Point Foundation	Outpatient	Ancho Program	201,565	201,565	41,993	8,399	50,391	25%	33	132	1,348	
SA Adult	Beyenne Hunters Point Foundation	Wellness Promotion & Prevention	HIV Ser Aide Routine Opt-Out HIV Screening Counseling, and Placement	25,000									
SA Adult	Beyenne Hunters Point Foundation	Residential Treatment	Jeann House Residential	631,417	262,420	32,603	32,603	65,205	10%	2	15	4,814	
SA Adult	Beyenne Hunters Point Foundation	Residential Treatment	Jeann Family Program Residential	572,315	572,315	71,539	71,539	143,079	25%	5	15	1,971	
SA Adult	Beyenne Hunters Point Foundation	Outpatient	Youth Moving Forward Bayview	563,930									
SA Adult	Beyenne Hunters Point Foundation	Outpatient	Youth Moving Forward Potrero Hill	165,241									
SA Adult	Beyenne Hunters Point Foundation	Prevention	LGBT Youth Services	4,211									
SA Adult	Beyenne Hunters Point Foundation	Prevention	Youth Services	105,245									
SA Adult	Beyenne Hunters Point Foundation	Mental Health	Neurotic Treatment Program MM	1,247,249									
SA Adult	Beyenne Hunters Point Foundation	Mental Health	Joe Methadone Counseling Drug Program	239,575									
SA Adult	Beyenne Hunters Point Foundation	Wellness Promotion & Prevention	Beyenne Hunter's Point Foundation	1,250,142	840,748	175,156	35,031	210,187	17%	-		36	
PLHJ	Beyenne Hunters Point Foundation - Total			7,646,266	2,181,106	304,435	160,441	464,877	6%	14	186	14,318	
PLHJ	Catholic Charities	Medical Case Management	Rita de Causa and Hazel Betsey	175,072						0%		40	1,555
PLHJ	Catholic Charities	Medical Case Management	David Sive	381,846	4,266	889	178	1,067	0%	0	66	2,754	

Initiative Back-Up Detail: CBO Across-the-Board Reductions. Agencies with no reductions are not included. If an agency has any reduction, then the entire agency is included in the detail.
as of 05-09-13

Section	Agency	Modality	Program/Provider	Total FY 12-13 Budget Less One-Time Funding	Total Non-Matched General Fund Money	FY14-15 Non-Matched General Fund Reductions (10 mos.)	FY14-15 Non-Matched General Fund Reductions (2 mos.)	Total General Fund Reductions	% General Fund Reduction of total Agency Funding	Estimated UDC Reduction Based on % of GP Reduction to Budgeted UDC	Total UDC	Total UOS (Mode 15 Mix vics converted to hours from minutes)
4JH	Catholic Charities	Residential Care Facility / Long Term Care	Peter Clever	451,378					0%		34	10,512
4JH	Catholic Charities	Supportive Services in Supportive Housing	Edith Vitti Senior Community	120,913	120,913	25,180	5,038	30,228	25%	7	29	1,488
4JH	Catholic Charities	Housing Subsidies	Assisted Housing	927,308								
Catholic Charities Total				2,008,078	128,179	28,078	5,216	31,295	2%	7	171	16,330
JA Adult	CATS	Hospitalized Stepdown	Medical Respite and Sobriety Center	1,521,751							367	34,278
JA Adult	CATS	Residential Treatment	Golden Gate for Seniors	266,895	266,895	33,362	33,362	66,724	25%	9	30	591
JA Adult	CATS	Wellness Promotion & Prevention	A Woman's Place	236,881								
JA Adult	CATS	Transportation	Mobile Assistance Fund	300,000								
JA Adult	CATS	Transportation	Mobile Assistance Fund	496,302								
JA Adult	CATS	Self Help/Drop In Center	Women's Drop-In/SHLN	832,864								
JA Adult	CATS	SFHOT	SF Homeless outreach Team	2,510,528								
CATS Total				6,189,338	266,895	33,362	33,362	66,724	1%	9	403	34,870
JA Child	Community Vocational Enterprises	Vocational Services	Vocational Services	12,888								
JA Adult	Community Vocational Enterprises	Peer & Intern Employment	Employment Services	208,707								
JA Adult	Community Vocational Enterprises	Vocational Services	Vocational Services	663,930	663,930	138,319	27,064	165,983	25%	100	400	64,113
JA Adult	Community Vocational Enterprises	Vocational Services	Vocational Services	215,970								
JA Adult	Community Vocational Enterprises	Vocational Services	IME Amnial Services	432,286								
JA Adult	Community Vocational Enterprises	Vocational Services	SF FIRST RCI	38,668								
JA Adult	Community Vocational Enterprises	Vocational Services	SF FIRST SPP-OP	31,541								
JA Adult	Community Vocational Enterprises	Vocational Services	Former Baker Paces Employees	157,532								
JA Adult	Community Vocational Enterprises	Vocational Services	Prompt Staffing Services	81,068								
Community Vocational Enterprises Total				1,650,851	663,930	138,319	27,064	165,983	9%	100	400	64,113
JA Adult	Curry Senior Center	Outpatient	Older Adult Integrated Full Service Outpatient	73,995	12,225	2,547	50,930	3,056	6%	4	95	171
JA Adult	Curry Senior Center	Outpatient	Behavioral Health Primary Care Integration	307,127								
JA Adult	Curry Senior Center	Outpatient	Older Adult BH FSGO	165,369	165,369	34,452	8,890	41,342	25%	13	51	33
JA Adult	Curry Senior Center	Outpatient	Curry Senior Center	361,541	361,541							
Curry Senior Center Total				908,032	529,135	34,999	7,400	44,398	5%	17	146	254
UH	Deborah Street Community Services	Supportive Services in Supportive Housing	Support Services at Casa Outcasts	305,425	325,423	67,796	13,559	81,356	25%	42	167	3,381
Deborah Street Community Services Total				325,423	325,423	67,796	13,559	81,356	25%	42	167	3,381
UH Child	Family Service Agency	Outpatient	EPISOT Full Circle	315,889								
UH Child	Family Service Agency	Outpatient	Quality Childcare mental health	423,225								
UH Child	Family Service Agency	Outpatient	Deaf Community Counseling etc	252,751								
UH Adult	Family Service Agency	Outpatient	PPPS ASD	181,176	30,375	8,328	1,266	7,594	4%	N/A	N/A	N/A
UH Adult	Family Service Agency	Outpatient	Older Adult FSP	1,141,632	71,269	14,848	2,870	17,817	2%	8	528	7,480
UH Adult	Family Service Agency	Outpatient	Geriatric Gough	830,230	260,819	54,337	10,807	65,205	7%	96	1,375	4,961
UH Adult	Family Service Agency	Outpatient	Odyssey Services	961,830	166,315	34,648	6,930	41,578	4%	51	1,180	5,380
UH Adult	Family Service Agency	Outpatient	Adult Full Service Partnership	1,343,184	122,226	25,464	5,093	30,557	2%	17	750	8,604
UH Adult	Family Service Agency	Outpatient	Transitional Age Youth	424,887								
UH Adult	Family Service Agency	Outpatient	Senior Drop In Center	185,400								
UH Adult	Family Service Agency	Outpatient	Wellness Promotion & Prevention	954,073								
UH Adult	Family Service Agency	Outpatient	Prevention & Recovery in Early Psychosis	397,496	192,688	40,143	8,828	48,172	12%	51	420	2,390
Family Service Agency Total				5,951,140	543,692	175,780	35,164	210,923	7%	324	4,203	26,820
JA Adult	Friendship House	Residential Treatment	Friendship House	217,741	217,741	27,218	27,218	54,435	25%	2	9	2,957
JA Adult	Friendship House	Residential Treatment	Friendship House	187,375								
Friendship House Total				405,116	217,741	27,218	27,218	54,435	13%	2	9	2,957
JA Child	Gift Community Housing	Supportive Services in Supportive Housing	149 Mason Street Housing Project	358,070	358,070	74,723	14,845	89,668	25%	15	61	18,117
Gift Community Housing Total				358,070	358,070	74,723	14,845	89,668	25%	15	61	18,117
JA Adult	HAFCI dba HealthRIGHT 360	Outpatient	Adult Outpatient	325,425								
JA Adult	HAFCI dba HealthRIGHT 360	Outpatient	Crisis Intervention	18,696	16,696	3,478	696	4,174	25%	N/A	N/A	4
JA Adult	HAFCI dba HealthRIGHT 360	Residential Treatment	WRAPS	82,400								
JA Adult	HAFCI dba HealthRIGHT 360	Outpatient	COOP	8,108	6,534	1,381	272	1,634	20%	-		
JA Adult	HAFCI dba HealthRIGHT 360	Outpatient	AA Family Healing Center	311,058	311,058	64,804	12,961	77,765	25%	25	101	3,684
JA Adult	HAFCI dba HealthRIGHT 360	Outpatient	Adult OP	1,240,223	1,210,223	252,130	50,426	302,556	24%	99	407	13,644
JA Adult	HAFCI dba HealthRIGHT 360	Outpatient	BASH Outpatient	90,183								
JA Adult	HAFCI dba HealthRIGHT 360	Vocational Services	HAFCI Admin Services	89,522								
JA Adult	HAFCI dba HealthRIGHT 360	Fiscal Intermediary	Project Homeless Connect - Everyday Connect	367,955								

Initiative Back-Up Detail: CBO Across the Board Reductions. Agencies with no reductions are not included. If an agency has any reduction, then the entire agency is included in the detail.												
as of 05-01-13												
Section	Agency	Modality	Program/Provider	FY13-14 Total 13 Budget Less One- Time Funding	Total Non- Matched General Fund Monies	FY13-14 Non- Matched General Fund Reductions (10 mos.)	FY14-15 Non- Matched General Fund Reductions (2 mos.)	Total General Fund Reductions	% General Fund Reduction of total Agency Funding	Estimated UDC Reduction Based on % of Reduction to Budgeted UDC	Total UDC	Total UDS (Note 15: Mit was converted to hours from minutes)
SA Adult	HAFC dsa healthRIGHT 300	Facial Intermediary	HIV Self-Audit Coordinator	120.000								
SA Adult	HAFC dsa healthRIGHT 300	Facial Intermediary	Project Homeless Connect	484.726								
SA Adult	HAFC dsa healthRIGHT 300	Outpatient	Biopsy Outpatient	730.438								
SA Adult	HAFC dsa healthRIGHT 300	Outpatient	2nd Chance Case Mgmt	500.588								
SA Adult	HAFC dsa healthRIGHT 300	Outpatient	SHOP grant	328.773								
SA Adult	HAFC dsa healthRIGHT 300	Outpatient	Family Strength Outpatient (Connectors)	200.457	200.457	41.762	8.352	50.114	25%	29	115	53
SA Adult	HAFC dsa healthRIGHT 300	Outpatient	Rap Payer Case Mgmt	77.614								
SA Adult	HAFC dsa healthRIGHT 300	Residential Treatment	BASIN Residential	432.525								
SA Adult	HAFC dsa healthRIGHT 300	Residential Detox	Social Detox Res Day/OP Lucille Wine Center	840.112								
SA Adult	HAFC dsa healthRIGHT 300	Residential Treatment	Salvitas Residential	303.983	303.983	37.998	37.998	75.996	25%	21	84	8,898
SA Adult	HAFC dsa healthRIGHT 300	Residential Treatment	WHITS Residential	313.899	313.899	30.237	30.237	78.475	25%	8	22	1,843
SA Adult	HAFC dsa healthRIGHT 300	Residential Treatment	SFHQ Residential	427.162	427.162	53.305	53.305	106.791	25%	11	45	3,381
SA Adult	HAFC dsa healthRIGHT 300	Residential Treatment	Transgender Residential	348.841	348.841	43.605	43.605	87.210	25%	9	36	2,621
SA Adult	HAFC dsa healthRIGHT 300	Residential Treatment	Adult Residential	3,660.484	950.437	118.005	118.005	237.809	8%	28	444	41,721
SA Adult	HAFC dsa healthRIGHT 300	Residential Treatment	Biopsy Residential	130.439								
SA Adult	HAFC dsa healthRIGHT 300	Residential Treatment	HIV Women's Residential (Lodestar)	160.973								
SA Adult	HAFC dsa healthRIGHT 300	Residential Treatment	CARE Variable Length Residential	217.326								
SA Adult	HAFC dsa healthRIGHT 300	Residential Treatment	CARE MSBP Residential	355.411								
SA Adult	HAFC dsa healthRIGHT 300	Residential Treatment	CARE Residential Detox	211.834								
SA Adult	HAFC dsa healthRIGHT 300	Residential Treatment	Women's Hope Residential (Pomona)	645.819	645.819	60.702	60.702	161.405	25%	9	35	5,259
SA Adult	HAFC dsa healthRIGHT 300	Residential Treatment	Criminal Justice Residential (AB109 WC)	311.850								
SA Adult	HAFC dsa healthRIGHT 300	Supportive Housing	Criminal Justice OHDP (AB109 WC)	351.542								
SA Adult	HAFC dsa healthRIGHT 300	Methodists	Superiority Medical Monitoring	50.437								
PLHJ	HAFC dsa healthRIGHT 300	Medical Case Management	Peasline Housing Program	70.796								
HAFC dsa healthRIGHT 300 Total				14,864,478	4,904,098	772,518	453,488	1,226,017	9%	285	1,504	30,839
MH-Adult	Hyde Street	Outpatient	Hyde Street	2,243,543	351.174	78,411	13,882	95,294	4%	12	3,310	12,855
MH-Adult	Hyde Street	Outpatient	Adult FSP	565,561	39,813	6,264	1,959	9,953	2%	4	253	3,411
Hyde Street Total				2,809,104	420,987	87,706	17,841	105,247	4%	16	3,563	16,266
MH-Child	Institute Family de la Raza, Inc.	Outpatient	outpatient	560.545								
MH-Child	Institute Family de la Raza, Inc.	Wellness Promotion & Prevention	Paul Rivera	103,629								
MH-Child	Institute Family de la Raza, Inc.	Wellness Promotion & Prevention	PEI Violence/Trauma Recovery Svc	214.351								
MH-Child	Institute Family de la Raza, Inc.	Wellness Promotion & Prevention	Early childhood MH	596.711								
MH-Child	Institute Family de la Raza, Inc.	Wellness Promotion & Prevention	PEI Early Childhood MH	42,000								
MH-Child	Institute Family de la Raza, Inc.	Wellness Promotion & Prevention	ECMHC Training	143.729								
MH-Adult	Institute Family de la Raza, Inc.	Outpatient	Adult Outpatient MH Svc	543.123	273,914	57,005	11,413	68,479	13%	108	855	2,923
MH-Adult	Institute Family de la Raza, Inc.	Outpatient	BMHC Integration	89,866	86,866	16,097	3,619	21,717	23%	99	395	3
MH-Adult	Institute Family de la Raza, Inc.	Wellness Promotion & Prevention	Indiana Health & Wellness COLL	254.775								
Institute Family de la Raza, Inc. Total				2,814,798	363,780	163,433	95,198		0%	0	287	1,286
SA Adult	Jewish, Inc. (JCC) FY13-14 Total	Residential Treatment	Jews House Residential	89,872	1,472	734	234	466	0%	0	6	77
SA Adult	Jewish, Inc. (JCC) FY13-14 Total	Residential Treatment	Casa Outright & Casa Open Adult Male Residential	16,472	643,172	40,387	40,387	160,793	21%	12	48	4,617
SA Adult	Jewish, Inc. (JCC) FY13-14 Total	Residential Treatment	Casa Outright & Casa Open - Perinatal Residential	374,264	374,264	46,787	46,787	93,574	25%	3	10	1,773
SA Adult	Jewish, Inc. (JCC) FY13-14 Total	Residential Treatment	Annie House Adult Male HIV Residential	175,184								
Jewish, Inc. (JCC) FY13-14 Total				1,946,280	1,017,466	127,163	127,163	256,367	13%	18	87	7,681
PLHJ	Lutheran Social Services of Northern California	Supportive Services in Supportive Housing	Ministry	54,359	54,359	11,325	2,265	13,590	25%	3	11	1,118
PLHJ	Lutheran Social Services of Northern California	Supportive Services in Supportive Housing	900 Park Street Senior Housing	213,537	213,537	44,487	6,697	53,384	25%	13	50	6,331
PLHJ	Lutheran Social Services of Northern California	Supportive Services in Supportive Housing	Viscain Drive	189,844	187,934	41,236	5,247	46,484	25%	10	40	5,603
PLHJ	Lutheran Social Services of Northern California	Supportive Services in Supportive Housing	3rd Party Payer	735,000	735,000	153,125	30,625	183,750	25%	328	1,313	13,654
PLHJ	Lutheran Social Services of Northern California	Emergency Housing	Emergency housing	271,860								
PLHJ	Lutheran Social Services of Northern California	Emergency Housing	Emergency housing	1,411								
PLHJ	Lutheran Social Services of Northern California	Emergency Housing	Emergency housing	89,607								
Lutheran Social Services of Northern California Total				1,461,734	1,200,830	250,173	40,838	300,208	18%	364	1,414	38,777
SA Adult	Lutheran Social Services of Northern California	Outpatient	Outpatient	254,775	254,775	53,078	10,616	63,694	25%	80	360	5,311
SA Adult	Mission Community	Outpatient	Outpatient	254,775	254,775	53,078	10,616	63,694	25%	13	51	2,231
Mission Community Total				509,550	509,550	106,156	21,232	127,388	25%	167	411	7,542
CJPC	Mission Neighborhood Health Center	Outpatient	Mission Neighborhood Health Center	302,628	302,628	63,498	12,610	75,657	25% NA	NA	NA	3,311

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Section	Agency	Modality	Program/Provider	Total FY 12-13 Budget Less One-time Funding	Total Non-Matched General Fund Monies	FY13-14 Non-Matched General Fund Reductions (10 mos.)	FY14-15 Non-Matched General Fund Reductions (2 mos.)	Total General Fund Reductions	% General Fund Reduction of Total Agency Funding	Estimated UDC Reduction Based on % Reduction of Budgeted UDC	Total UDC	Total UDC (Phase 15 MHI events converted to hours from minutes)
	Mission Neighborhood Health Center Total											
				302,628	302,435	83,843	12,810	78,057	25%	-	-	3,104
PH CHRG	Mr. St. Joseph's - St. Elizabeth's	Outpatient	outpatient	62,627								
SA Adult	Mr. St. Joseph's - St. Elizabeth's	Residential Treatment	Epiphany House	334,619	334,618	41,827	41,827	83,655	25%	6	30	3,265
SA Adult	Mr. St. Joseph's - St. Elizabeth's	Residential Treatment	Epiphany Residential	334,617	334,617	41,827	41,827	83,654	25%	6	30	3,265
PH CHRG	Mr. St. Joseph's - St. Elizabeth's	Supportive Services in Supportive Housing	Permanent Housing for Homeless Fetal Server	731,962	619,238	13,654	187,300	234	25%	18	60	6,870
				53,099	53,099	11,054	2,211	13,265	25%	6	22	2,446
	Parishew Terrace Total											
PH Adult	Progress Foundation, Inc.	Residential Treatment	Cortland	191,549	187,460	20,834	20,834	41,867	5%	4	80	8,395
PH Adult	Progress Foundation, Inc.	Residential Treatment	Dore Street Urgent Care Clinic	2,456,692	765,619	96,240	96,240	192,480	8%	78	1,000	35,000
PH Adult	Progress Foundation, Inc.	Residential Treatment	Auburn	973,398	190,511	22,564	22,564	45,129	5%	1	24	8,551
PH Adult	Progress Foundation, Inc.	Residential Treatment	Avenues	1,421,993	496,442	58,305	58,305	116,611	8%	41	498	7,443
PH Adult	Progress Foundation, Inc.	Residential Treatment	Clay	1,451,211	157,567	18,695	18,695	36,389	3%	1	40	12,750
PH Adult	Progress Foundation, Inc.	Residential Treatment	Dore Street Residential	1,462,193	471,217	56,902	56,902	117,804	9%	44	550	6,890
PH Adult	Progress Foundation, Inc.	Residential Treatment	Corrine Lee House	1,207,884	69,354	8,544	8,544	17,089	1%	1	36	12,314
PH Adult	Progress Foundation, Inc.	Residential Treatment	La Amada	922,140	323,118	40,265	40,265	80,530	10%	15	150	10,153
PH Adult	Progress Foundation, Inc.	Residential Treatment	La Piedad	1,175,879	377,367	47,171	47,171	94,342	8%	32	394	6,296
PH Adult	Progress Foundation, Inc.	Residential Treatment	Progress House	791,995	185,293	20,662	20,662	41,323	5%	4	60	8,414
PH Adult	Progress Foundation, Inc.	Residential Treatment	Services Program	1,153,384	103,372	12,922	12,922	25,843	2%	2	88	11,668
PH Adult	Progress Foundation, Inc.	Residential Treatment	Strader	1,216,722	438,109	54,764	54,764	109,527	9%	45	498	7,801
PH Adult	Progress Foundation, Inc.	Supportive Housing	Supportive Living	661,849								
				14,922,338	3,867,728	466,996	466,996	921,932	6%	288	3,438	134,677
PH CHRG	Progress Foundation Total	Supportive Services in Supportive Housing	Armstrong Plaza	99,891	99,891	20,559	4,112	24,670	25%	6	25	2,112
				96,881	96,881	20,559	4,112	24,670	25%	6	25	2,112
PH CHRG	RAMS	Outpatient	inpatient	570,095								
PH CHRG	RAMS	Outpatient	outpatient	1,033,795								
PH CHRG	RAMS	Outpatient	SED partnership	303,955								
PH CHRG	RAMS	Wellness Promotion & Prevention	PEI school-based services	270,539								
PH CHRG	RAMS	Wellness Promotion & Prevention	MHSA WDET Summer Bridge	68,240								
PH CHRG	RAMS	Wellness Promotion & Prevention	PEI Early Childhood MH	25,478								
PH CHRG	RAMS	Wellness Promotion & Prevention	Early childhood MH	934,719								
PH Adult	RAMS	Outpatient	Adult Outpatient Services Clinic	1,881,035	34,554	7,199	1,440	8,639	0%	6	1,200	10,440
PH Adult	RAMS	Outpatient	Brookview Street Residential Program	565,187	10,593	2,207	441	2,649	0%	0	36	2,455
PH Adult	RAMS	Training	Peer Specialist Mental Health Certificate	135,548								
PH Adult	RAMS	Vocational Services	Employee Development Program	111,341	111,341	23,196	4,639	27,835	25%	9	30	3,561
PH Adult	RAMS	Vocational Services	IT	510,000								
PH Adult	RAMS	Outpatient	MHI Health Party Cussion	100,000								
PH Adult	RAMS	Vocational Services	SF FIRST RC	5,096								
PH Adult	RAMS	Vocational Services	SF FIRST SFPL-OP	4,421								
PH Adult	RAMS	Vocational Services	Former Baker Police Employee	22,565								
PH Adult	RAMS	Vocational Services	Prompt Staffing Services	13,010								
PH Adult	RAMS	Vocational Services	Empowerment Services	29,967								
PH Adult	RAMS	Vocational Services	Wellness assistance music services	125,768	125,795	26,205	5,241	31,446	25%	N/A	N/A	N/A
PH Adult	RAMS	Vocational Services	MEJL Janitorial Services	61,755								
PH Adult	RAMS	Vocational Services	Janitorial Services	1,841								
PH Adult	RAMS	Outpatient	Wellness assistance music services	160,072								
PH Adult	RAMS	Outpatient	PAES - SSI Advocacy Support Service	85,178								
PH Adult	RAMS	Outpatient	PAES Vocational inc	80,854								
PH Adult	RAMS	Outpatient	PAES Counselor & Pre-Counseling	1,670,140								
PH Adult	RAMS	Residential	Brookview Street RCF	833,706	833,706				0%		39	11,081
				9,030,305	1,515,719	50,607	11,761	70,368	1%	14	1,207	23,527
PH CHRG	Regents of California (UC)	Supportive Services in Supportive Housing	Person 0	651,949	499,695	104,103	20,621	124,724	20%	13	67	160,871
PH CHRG	Regents of California (UC)	Vocational Services	Dept of Psychiatry Vocational Rehabilitation	43,556	43,556	6,074	1,945	10,869	25%	1	5	12,452
				875,844	543,251	114,177	22,635	136,812	20%	14	72	193,183
PH Adult	San Francisco AIDS Foundation	Outpatient	Lynn Martin	396,920	317,840	66,259	13,248	79,455	21%	19	93	1,999
PH Adult	San Francisco AIDS Foundation	Outpatient	Stonewall Project	86,064	1,604	334	67	401	0%	0	20	650
SA Adult	San Francisco AIDS Foundation	Outpatient	Subcontract to Lynn Martin Health Services	171,100	171,100	39,646	7,129	42,775	25%	4	15	774

Initiative Bars City Total CBO Across-the-Board Reductions Agencies with no reductions are not included. If an agency has any reduction, then the entire agency is included in the detail.																		
as of 08-03-13																		
Section	Agency	Modality	Program/Provider	Total FY 12 13 Budget Less One- time Funding	Total Non- Matched General Fund Monies	FY13-14 Non- Matched General Fund Reductions (10 mos.)	FY14-15 Non- Matched General Fund Reductions (2 mos.)	Total General Fund Reductions	% General Fund Reduction of total Agency Funding	Estimated UDC Reduction Based on % of GF Reduction to Budgeted UDC	Total UDC	Total UDCS (Wade 15 Min converted to hours from minutes)						
SA Adult	San Francisco AIDS Foundation	Outpatient	StoneWall Project HIV Intervention	157,741						-								
SA Adult	San Francisco AIDS Foundation	Outpatient	StoneWall Project IF SO	410,432	402,432	63,840	16,768	100,608	25%	23	95	4,004						
SA Adult	San Francisco AIDS Foundation	Outpatient	StoneWall Project IF SO	140,152	140,152	29,198	5,840	35,038	25%	-	-	-						
SA Adult	San Francisco AIDS Foundation	Outpatient	StoneWall Project PROP	122,399	122,399	25,500	5,100	30,600	25%	13	50	1,612						
PLMN	San Francisco AIDS Foundation	Housing Subsidies	Rental Subsidies	2,096,528														
PLMN	San Francisco AIDS Foundation	Housing Subsidies	Rental Subsidies	625,995														
	San Francisco AIDS Foundation Total			6,098,721	1,155,627	240,798	46,181	288,979	8%	9	275	8,438						
MH-Adult	San Francisco Study Center	Client Rights Advocacy	SFMRCA (SF Men Clients Rights Advocacy)	370,827	370,827	77,276	15,455	92,732	25%	150	600	9,172						
MH-Adult	San Francisco Study Center	Peer & Intern Employment	Peer & Intern Employment	960,654														
MH-Adult	San Francisco Study Center	Wellness Promotion & Prevention	OSH (OFFICE OF SELF-HELP)	577,810	444,010	92,502	18,500	111,003	19%	38	200	14,525						
MH-Adult	San Francisco Study Center	Innovation	Fiscal Intermediary for Innovation	307,178														
MH-Adult	San Francisco Study Center	COOB	COOB	18,122	15,565	3,243	649	3,891	21%	-	-	72						
CHRP	San Francisco Study Center	Wellness Promotion & Prevention	San Francisco Study Center	1,352,460	330,520	88,858	13,772	82,630	6%	-	-	-						
	San Francisco Study Center Total			3,817,281	1,181,022	241,680	46,378	295,296	8%	165	800	22,770						
MH-Adult	San Francisco Suicide Prevention	Wellness Promotion & Prevention	Citizens Suicide Intervention / Crisis Counseling / Off-hours Coverage for Behavioral Health SOC, BHAC Line Coverage	181,860														
SA Adult	San Francisco Suicide Prevention	Training	Fiscal Intermediary-Training Fund	45,850														
SA Adult	San Francisco Suicide Prevention	Training	Fiscal Intermediary-Training Fund	199,489	199,489	41,560	8,312	49,872	25%	-	-	4,160						
SA Adult	San Francisco Suicide Prevention	Wellness Promotion & Prevention	Drug/Life/Respite Prevention Line	100,459														
SA Adult	San Francisco Suicide Prevention	Mentorship	Fiscal Intermediary-Item Reduction Therapy	35,365														
	San Francisco Suicide Prevention Total			651,163	199,489	41,560	8,312	49,872	9%	-	-	4,160						
MH-Adult	SF Men's Education Funds	Training	Mental Health Board	129,891	100,824	21,026	4,205	25,231	19%	230	1,183	634						
MH-Adult	SF Men's Education Funds	Training	CBHS CME Training Fund	18,945	18,945	3,760	752	4,512	25%	206	1,183	116						
MH-Adult	SF Men's Education Funds	Training	CBHS SOC Training Fund	40,603	40,603	8,459	1,692	10,151	25%	296	1,183	262						
	SF Men's Education Funds Total			189,440	159,372	33,245	6,649	39,893	21%	822	3,548	1,212						
PLMN	Baypointe Home	Outpatient	Mission Care	259,790	259,790	54,123	10,925	64,948	25%	39	156	5,670						
	Baypointe Home Total			259,790	259,790	54,123	10,925	64,948	25%	39	156	5,670						
MH-Child	The IRIS Center	Outpatient	Mental Services	35,860														
SA Adult	The IRIS Center	Outpatient	FSO Perinatal Program	711,933	388,848	78,843	15,369	92,212	13%	10	81	17,157						
	The IRIS Center Total			747,652	388,848	78,843	15,369	92,212	13%	10	81	17,157						
MH-Adult	UCSF Alliance Health Project	Outpatient	Transgender	26,187	26,187	5,408	1,092	6,549	25%	100	400	74						
MH-Adult	UCSF Alliance Health Project	Outpatient	Integrated Full Service Outpatient	718,702	19,824	2,278	455	2,733	9%	3	903	3,698						
MH-Adult	UCSF Alliance Health Project	Outpatient	COOB	14,228	14,228	2,964	593	3,557	25%	-	-	-						
	UCSF Alliance Health Project Total			151,440														
MH-Adult	UCSF Alliance Health Project	Outpatient	Integrated Full Service Outpatient	610,867	81,348	10,899	2,140	12,837	1%	143	1,303	3,770						
MH-Adult	UCSF Citywide CM & CRT	Outpatient	Citywide Linkage	630,813	414,382	66,330	17,266	103,596	12%	39	315	8,925						
MH-Adult	UCSF Citywide CM & CRT	Outpatient	NOVA	165,984														
MH-Adult	UCSF Citywide CM & CRT	Outpatient	Raising Line	815,511														
MH-Adult	UCSF Citywide CM & CRT	Outpatient	Supportive Services in Supportive Housing	645,397														
	UCSF Citywide CM & CRT Total			44,917	13,917	2,899	580	3,479	5%	3	65	1,855						
MH-Adult	UCSF EPR	Outpatient	Citywide Focus	6,189,650	213,857	44,554	6,911	53,464	1%	4	480	36,875						
MH-Adult	UCSF EPR	Outpatient	Citywide Forefront	1,836,379	62,430	19,360	3,872	23,232	1%	2	173	8,792						
	UCSF EPR Total			7,996,029	266,187	63,914	12,783	76,697	1%	7	143	46,667						
WHS	Unidentified TBC	Unidentified	Unidentified	4,571,705		46,771	32,451	81,221		-	-	-						
	Unidentified Total			4,571,705		46,771	32,451	81,221		-	-	-						
MH-Child	Westside Community Mental Health	Outpatient	support	1,125,064														
MH-Child	Westside Community Mental Health	Outpatient	SEED partnership	161,741														
	Westside Community Mental Health	Outpatient	Teams for Understanding and Compassion Program	-														
MH-Adult	Westside Community Mental Health	Emergency Crisis	Westside Crisis	1,394,366	440,711	91,815	16,383	110,178	8%	273	3,350	317,715						
MH-Adult	Westside Community Mental Health	Outpatient	Westside FSO Outpatient	1,256,330	157,999	32,918	8,583	38,500	3%	26	906	6,553						
MH-Adult	Westside Community Mental Health	Outpatient	Westside Crisis Care	1,761,584	68,096	14,187	2,837	17,024	1%	8	570	10,520						

Initiative Back-Up Detail: CBO Across-the-Board Reductions. Agencies with no reductions are not included. If an agency has any reduction, then the entire agency is included in the detail.											
as of 05-02-13											
Section	Agency	Modality	Program/Provider	Total FY 12-13 Budget Less One-Time Funding	Total Non-Matched General Fund Monies	FY13-14 Non-Matched General Fund Reductions (10 mos.)	FY14-15 Non-Matched General Fund Reductions (2 mos.)	Total General Fund Reductions	% General Fund Reduction of total Agency Funding	Estimated UDC Reduction Based on % of GF Reduction to Budgeted UDC	Total UDC (Made 15 Mnt a/c converted to hours from minutes)
SA Adult	Westside Community Mental Health	Outpatient	Westside CTL (HIV Counseling, Testing & Litigation)	70,000	-	-	-	-	0%	-	300
MH-Adult	Westside Community Mental Health	Outpatient	CAVORKA PROGRAM	1,972,305	11,460	2,368	478	2,865	0%	4	2,434
SA Adult	Westside Community Mental Health	Methadone	Westside Methadone Maintenance	1,388,670	-	-	-	-	-	-	-
SA Adult	Westside Community Mental Health	Methadone	Westside Methadone Maintenance Long-term Order	18,610	-	-	-	-	-	-	-
Westside Community Mental Health Total				9,138,060	678,386	141,305	29,281	169,967	2%	310	7,554
Grand Total:				147,966,573	30,784,692	4,765,389	3,112,672	6,978,038	5%	4,258	38,445

Restorations Following April 23, 2013 Health Commission Hearing											
Section	Agency	Modality	Program/Provider	Total FY 12-13 Budget Less One-Time Funding	Total Non-Matched General Fund Monies	FY13-14 Non-Matched General Fund Restoration (10 mos.)	FY14-15 Non-Matched General Fund Restoration (2 mos.)	Total General Fund Restorations		Total UDC	Total UDC (Made 15 Mnt a/c converted to hours from minutes)
CHPP	Bayview HERC	Wellness Promotion & Prevention	Bayview HERC	303,844	303,844	63,322	10,864	74,186		509	5,064
SA Adult	City College of San Francisco	Training	SA Certificate Program	132,088	132,088	27,518	5,504	33,022		30	9,638
SA Adult	Harm Reduction Coalition	Outpatient	DOPE Project	174,070	137,712	28,690	5,738	34,428		1,576	2,316
CDCC	Lighthouse for the Blind and Visually Impaired	Transportation	Lighthouse for the Blind and Visually Impaired	51,497	51,497	10,729	2,146	12,874		100	1,605
MH-Adult	NICOS	Wellness Promotion & Prevention	Chinese Community Problem Gambling Project	69,280	68,280	14,223	2,845	17,070		529	1,067
MH-Adult	SAGE Project	Outpatient	Survivors of Trauma, Violence, and Sexual Abuse	71,337	71,337	14,862	2,972	17,834		48	855
SA Adult	SAGE Project	Outpatient	Survivors of Trauma, Violence, and Sexual Abuse	132,483	132,483	27,601	5,520	33,121		50	2,348
CDCC	San Francisco Consortium	Primary Care	San Francisco Consortium (Interim) Project	41,000	41,000	8,542	1,708	10,250		N/A	N/A
MH-Adult	San Francisco Suicide Prevention	Wellness Promotion & Prevention	Citizenship Suicide Intervention / Crisis Counseling / Off-hour Coverage for Behavioral Health SOC, BHAC Line Coverage	181,960	181,960	37,608	7,582	45,190		5,000	4,150
SA Adult	San Francisco Suicide Prevention	Wellness Promotion & Prevention	Drug Use/Relapse Prevention Line	100,459	100,459	20,929	4,186	25,115		1,400	3,185
CDCC	Shanté Lifelines	Transportation	Shanté Lifelines	54,548	54,548	13,448	2,690	16,137		-	-
CDCC	Trauma Center	Primary Care	Trauma Foundation aka Women's Comm Health Ctrc	50,955	50,955	10,876	2,123	12,729		520	561
				1,372,621	1,336,263	278,388	65,678	334,066	-	-	8,792

Grand Total of All DPH CBO Professional Services Funding Impact											
				Total Funding	Total General Fund	Total General Fund Reduction*	Percent GF Reduction of Total GF	Total Prof Services Reduction (all funding sources)**	Percent Profession Reduction of Total Professional Services		
				368,808,145	118,841,303	10,011,018	9%	13,263,179	8%		
* Included in the reduction is the projected loss of \$1,032,981 in General Fund monies that were used to backfill Ryan White HIV Funding in FY12-13, but of the total this portion was not ongoing on FY13-14. Added to Across-the-Board reduction											
** Included in this reduction is the additional Federal grant losses to HIV Health Services and HIV Prevention in FY13-14 and 14-15. Reduction to total Professional Services would decrease from 5% to 3% if HIV funding losses not included											



City & County of San Francisco

Office of the Mayor



Mayor Edwin M. Lee
"Interrupt, Predict, and Organize for a Safer San Francisco":



City & County of San Francisco

Office of the Mayor



In July 2012 Mayor Lee announced a new violence prevention and intervention initiative- “Interrupt, Predict, and Organize for a Safer San Francisco” (IPO). As a part of the IPO, multiple goals and objectives are outlined to ensure public safety.



City & County of San Francisco
Office of the Mayor



IPO Strategy

- Interrupt the violence through enforcement.
- Predictive policing for an effective violence prevention strategy.
- Organize social service agencies, enforcement agencies, non-profit organizations, faith-based organizations, and businesses to work collaboratively in providing violence prevention services and in promoting a safer San Francisco.



Interrupt: Targeted Enforcement Zone Strategy 2.0

- Violence Response Teams (e.g. street crime suppression, robbery abatement, saturation and decoy operations)
- “Ceasefire” meetings
- Fugitive Recovery Enforcement
- Get the Guns! (enforcement and gun source tracing with ATF, gun buybacks, and incentives for information)
- Youth and family programs (e.g. Family and Education over Everything, and Our Kids ‘O.K.’)



City & County of San Francisco

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Predict: Predictive Policing

- Technology for real-time crime analysis and information sharing to rapidly deploy resources to areas where crimes are likely to occur (e.g. forwarding updated hot spot maps to mobile units).
- Promising software implemented by LA, Chicago, Charleston, Memphis, San Cruz and others.
- Declared on the Best Inventions of 2011 by Time Magazine.



Organize: For a Safer San Francisco

- Organize social service agencies, enforcement agencies, non-profit organizations, faith-based organizations, and businesses to work collaboratively and coordinated in providing violence prevention services in high crime neighborhoods.
- Implement coordinated enforcement and prevention strategy.
- Implement a coordinated service strategy targeting high crime neighborhoods and addressing early intervention and workforce needs.
- Implement a public messaging campaign promoting a “stop to violence.”
- Education and community mobilization through community gatherings, events, and faith based gatherings.

Interrupt, Predict, and Organize for a Safer San Francisco

Interrupt

SFPD Zone Strategy

Gang Enforcement
Interventions

School Based Interventions

Violence Response Teams

Public Housing Outreach

Availability of Firearms

Targeted Street Outreach
and Intervention

Supervision of
Probationers, PCRS

Predict

Predictive Policing
Strategies

Reentry Risk Assessments /
Release Plans

Organize

City and County
Coordination

Enforcement and
Prevention Strategy

Social Service Strategy

Public Messaging Campaign

Education and Community
Mobilization

DRAFT



Organize

City and
County
Coordination

Coordination
Meetings
(Principals, Public Safety
Cluster and SVRT)

Enforcement
and
Prevention

Adult and
Juvenile Case
Conferencing
Models

Juvenile
Restorative
Justice
Compelling

Employment
Alliances
Youth & 18-25
(LAI Out)

Social
Services

Family Resource
Centers

Adult and
Juvenile Strategy
Centers
(LAI Out)

Public
Messaging
Campaign

Anti-Domestic
Violence

Anti-Street
Violence

Education and
Community
Mobilization

Community
Peace Forums
and Events

Community
Based Providers
Forum
(18-25 CJ)

City and County
Programs
Training



City & County of San Francisco
Office of the Mayor



IPO Planning Timeline

Item (s)	Deadline(s)
City Agency Input and Feedback	December 31, 2012
Community Input	February 28, 2013
<i>OMI Peace Forum</i>	<i>November 15th, 2012</i>
	<i>TBD</i>
<i>Bayview Peace Forum</i>	<i>January 31st & February 28th,</i>
<i>Mission Peace Forum(s)</i>	<i>6-8pm, Good Samaritan</i>
	<i>February 7th</i>
<i>Western Addition Peace Forum</i>	<i>Location and Time TBD</i>
First Draft Review	March 31, 2013
Final IPO Plan	April 31, 2013





SAN FRANCISCO MENTAL HEALTH BOARD

Mayor Edwin Lee

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www.sfgov.org/mental_health

MEETING OF THE MENTAL HEALTH BOARD

Wednesday, June 12, 2013

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

6:30 PM – 8:30 PM

06-03-13A08:09 RCVD

CALL TO ORDER

ROLL CALL

GOVERNMENT
DOCUMENTS DEPT

AGENDA CHANGES

JUN - 3 2013

Item 1.0 DIRECTORS REPORT

For discussion.

SAN FRANCISCO
PUBLIC LIBRARY

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public Comment

Item 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

For discussion.

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Updates

2.2 Public Comment

Item 3.0 ACTION ITEMS

For discussion and action.

3.1 Public comment

3.2 PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of May 8, 2013 be approved as submitted.

3.3 PROPOSED RESOLUTION (MHB- 2013-XX): That the Mental Health Board Urges the Mayor and the Board of Supervisors to reject the proposed cuts of mental health and substance abuse services by the Department of Public Health.

Item 4.0 PRESENTATION: MENTAL HEALTH BOARD ROLES AND RESPONSIBILITIES, CARY MARTIN, PRESIDENT, CALIFORNIA ASSOCIATION OF LOCAL MENTAL HEALTH BOARDS AND COMMISSIONS (CALMHBC)

4.1: Presentation: Mental Health Board Roles and Responsibilities, Cary Martin, President, California Association of Local Mental Health Boards and Commissions (CALMHBC)

4.2 Public Comment

Item 5.0 REPORTS
For discussion

5.1 Report from the Executive Director of the Mental Health Board.
Discussion regarding upcoming events, conferences, or activities that may be of interest to board members; Mental Health Board budget issues and update on staff work on board projects.

5.2 Report of the Co-Chairs of the Board and the Executive Committee.
Discussion regarding Chair's meetings with Community Behavioral Health Services staff, meetings with members of the Board of Supervisors and community meetings about mental health or substance abuse.

5.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

5.4 Report by members of the Board on their activities on behalf of the Board.

5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

5.6 Public comment.

6.0 PUBLIC COMMENT

ADJOURNMENT

DISABILITY ACCESS

1. Room 278 is accessible to persons using wheelchairs and others with disabilities. Assistive listening devices, materials in other alternative formats, American Sign Language interpreters and other accommodations will be made available upon request. Please contact Darlene Daevu, Community Behavioral Health Services, 415-255-3426 or by email: Darlene.daevu@sfdph.org. Providing at least 72 hours notice will help to ensure availability. To reach a TTY line, call (415) 255-3449. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at City Hall, One Dr. Carlton B. Goodlett Place (between Grove and McAllister), in Room 278. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 71 Haight/Noriega. Also, the J, K, L, M, and N lines underground. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. Special Hearings are usually held at the Department of Public Health, 101 Grove Street, 3rd Floor, Room 300. The same public transportation options as above apply. It is wheelchair accessible.

4. For Special Hearings at other locations, please call for directions or bus information. All locations will be accessible.

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The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: sotf@sfgov.org

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from the Task Force or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: www.sfgov.org/sunshine

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: www.sfgov.org/mental_health. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

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Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics



**MAYOR
EDWIN LEE**

SAN FRANCISCO MENTAL HEALTH BOARD

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MENTAL HEALTH BOARD

June 12, 2013

Attachment A

PROPOSED RESOLUTION (MHB- 2013-XX): THAT THE MENTAL HEALTH BOARD URGES THE MAYOR AND BOARD OF SUPERVISORS TO REJECT THE PROPOSED CUTS OF MENTAL HEALTH AND SUBSTANCE ABUSE SERVICES.

WHEREAS, the Department of Public Health of the City and County of San Francisco has proposed cuts of up to 25% of many mental health and substance abuse programs, and;

WHEREAS, these cuts may have the unintended consequence of eliminating these needed programs, and;

WHEREAS, these cuts will adversely impact services vital for the community's mental health and well being, and;

WHEREAS, the costs to the community of untreated mental illness are tragic including increased emergency room visits and costs, domestic abuse, rise in crime, school violence, substance abuse, homelessness and suicide, and;

WHEREAS, city and state revenues have actually increased beyond projections, and;

WHEREAS, the Mental Health Board believes that the City has a moral or ethical duty to care for those people who are ill, suffering, in trouble, and in need; and,

WHEREAS, the success of Community Behavioral Health programs have shown that with adequate and proper treatment, people can recover, and break the destructive cycle linked to mental illness and substance abuse; and,

BE IT RESOLVED that the Mental Health Board of San Francisco urges the Mayor and the Board of Supervisors to reject the proposed cuts of up to 25% for many mental health and substance abuse programs by the Department of Public Health





Edwin Lee
Mayor

SAN FRANCISCO MENTAL HEALTH BOARD

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Unadopted Minutes

Mental Health Board

Wednesday, June 12, 2013

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

San Francisco, CA

GOVERNMENT
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JUL - 5 2013

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BOARD MEMBERS PRESENT: Ellis Joseph, MBA, Co Chair; David Elliott Lewis, Ph D, Co Chair; Wendy James, Vice Chair; Virginia S. Lewis, MA, LCSW, Secretary; Terry Bohrer, RN, MSW, CLNC; Kara Chien, JD; Marlene Flores; Sgt. Kelly Kruger; and Errol Wishom.

BOARD MEMBERS ON LEAVE: Melody Daniel, MFT; Terence Patterson, EdD, ABPP; and Alphonse Vinh, MS; and Lena Miller, MSW.

BOARD MEMBERS ABSENT:

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jo Robinson, Director of Community Behavioral Health Services (CBHS); Cary Martin, San Joaquin County Mental Health Board Member, President, California Association of Local Mental Health Boards and Commissions; Donna Martin, Vanac Tran; Wendy Yu; Martha Stein; Derrick Williams and two members of the public.

CALL TO ORDER

Mr. Joseph called the meeting of the Mental Health Board to order at 6:45 PM.

ROLL CALL

Ms. Brooke called the roll.

AGENDA CHANGES

There were no changes to the agenda.

ITEM 1.0 DIRECTOR'S REPORT

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

Ms. Robinson highlighted the following items which are included in the June Director's report.

The final budget for the FY 2013-2014 was approved with Mayor Ed Lee restoring and/or backfilling most of the DPH (Department of Public Health) cuts. His actions mean there will not be any loss in services to clients or loss of jobs.

The Mayor would like to RFP (request for proposals) out as much as possible on non-revenue generating services, since subsidies for these services must be met with the City's General Funds.

DPH is moving forward with the 2014 Affordable Care Act (ACA), also known as the Obama Care Act. CBHS is consulting with HMA (Health Management Associates) and five committees were established to plan for the ACA implementation.

San Francisco Health is the new healthcare delivery system with new classifications and procedural changes. Mental health and substance abuse will be categorized as ambulatory care. Jail health services will be known as outpatient and special care services. Laguna Honda Hospital and the SFGH (San Francisco General Hospital) will be known as institutional care. This new healthcare delivery system will penalize the City if an individual is re-hospitalized within 30 days of a previous hospital discharge.

For example, the initial critical care is patient stabilization. Then recovery and supportive care is done through ambulatory care or a residential care.

She suggested the board should have an ACA presentation. Barbara Garcia has been planning several stake holder meetings to address changes resulting from the ACA.

Mental health and substance abuse are still being carved out. The services are funded by special financial resources from the State of California and mental health plans rather than through the City's General Funds.

She believed behavioral health will move towards managed care, integrating with mental health, substance abuse and primary care. The next three months is a serious planning period. This coming October is the start of the health insurance renewal process, and San Francisco's healthcare delivery must be up and running by January 2014. The department anticipates the initial transition period to be challenging; but they hope clients/patients will get used to the new system quickly.

Ms. Virginia Lewis asked how health insurance exchanges of the ACA works.

Ms. Robinson explained that consumers can just think of ACA's health insurance exchanges as a State or Federal online marketplace offering private insurance -- just as travelers can choose their travel itinerary through online travel companies like Kayak, Priceline or Travelocity.

Mr. Joseph asked about specialized healthcare homes for home-bound clients with severe mental health needs.

Ms. Robinson said that for mentally ill people who are uncomfortable at going to their primary doctor for care, they can get their care at more than 30 Medical Homes, most of which are clinics.

Dr. David Elliott Lewis asked if money will be saved under the Mayor's Office requirement to RFP out services.

Ms. Robinson said money will be saved. The Mayor's Office wants DPH to reduce the amount of these financial contracts. If the current rate is allowed to continue, then in five years DPH would be running a \$1.5 billion in deficit.

Ms. Virginia Lewis asked for clarification on revenue generating services.

Ms. Robinson said MediCal reimbursements are revenue generating services. But healthcare services in ADUs (Acute Diversion Units) are reimbursed at lower rates by MediCal.

A way to save money is for MediCal patients/clients in non-acute beds to be transferred to lower services so they would be no longer considered non-acute by MediCal. MediCal does not reimburse the following services: acute diversion, out-patient care, substance abuse residential care, group services and board and care services

Under the ACA, immigration status and income will determine a client/patient qualification. Since San Francisco is a sanctuary city, ineligible ACA consumers will continue to receive care, even though the City cannot bill for reimbursement. In essence, San Francisco has great services but also most costly based on our data and outcomes.

Monthly Director's Report **June 2013**

1. A new Suicide Attempt Survivor Support Group in San Francisco

The Mental Health Association of San Francisco (www.mentalhealthsf.org) and the San Francisco Suicide Prevention Center (www.sfsuicide.org) have created a customized group specifically for individuals who are suicide attempt survivors. This group will be clinically guided by supervised peer leaders, will utilize the Wellness Recovery Action Plan (WRAP) curriculum and will occur weekly for 12 weeks. For full details contact Jennifer Awa at the Mental Health Association of San Francisco at (415) 341-9507 or jenn@mentalhealthsf.org.

2. Strengthening Families Program

Strengthening Families Program for Parents & Teens
Ages 12-14

For more information contact: julia.barboza@bayviewci.org

(See attachment 1)

3. Transgender Wellness and Recovery RAP Group

R is for Respect, A is for Answers, and P is for Positive Journeys

Starting Dates: June 11th and June 25th / and every 2nd and 4th Tuesday of every Month

Time: 12:45pm – 1:45pm

Where: BHAC Conference Room on the first floor of 1380 Howard Street

Facilitators: Jamie Armstrong / Annette Quiett

4. New Binge Drinking Intervention Available

(See attachment 2)

5. CDC Issues Comprehensive Report on Children's Mental Health

A new Centers for Disease Control and Prevention (CDC) Morbidity and Mortality Weekly Report (MMWR) Supplement finds that between 13% and 20% of American children live with depression, anxiety, ADHD, autism spectrum disorders, Tourette syndrome, and a host of other mental health issues. (ADHD is the most common diagnosis, followed by behavioral and conduct problems). The total annual cost of this prevalence of mental illness is about \$247 billion a year. Compiling information from various data sources covering 2005-2011, the MMWR Supplement is the first-ever report to describe federal efforts to monitor mental disorders, as well as to offer estimates of the number of children aged 3-17 years with specific mental disorders. According to the report, up to one in five U.S. children experiences a mental disorder each year. Attention-deficit/hyperactivity disorder (AD/HD) is the most prevalent diagnosis, and suicide, which can result from the interaction of mental disorders and other factors, was the second-leading cause of death among adolescents in 2010. "This report is an important step to better understand children's mental disorders, identify gaps in data, and develop public health strategies to protect and promote children's mental health, so children can reach their full potential in life," according to a CDC news release.

6. Hepatitis C Management Presentation

Date: Thursday, June 20, 2013

Time: 8:30am – 12:00pm

For more information or to register, go to <http://tinyurl.com/HepCJune2013>

(See attachment 3)

7. Save the Date – Clinical Care for Transgender People

Beyond the Basics: Clinical Care for Transgender People

Date: October 1, 2013

Time: 9:00am - 5:00pm

For more information contact: julie.graham@sfdph.org

(See attachment 4)

8. Diane Prentiss to Serve as an Expert

Our own Diane Prentiss has been invited by the California Institute for Mental Health to join a panel of national experts that will guide and inform changes. These changes will be pursued in a learning collaborative designed to improve recovery outcomes of individuals with serious mental illness. The collaborative will help mental health programs to make fundamental changes that promote recovery for individuals with serious mental illness. The program changes will help people to develop meaningful, self-directed lives in their communities with a focus on improved health, housing, purpose in daily life, and relationships in their community. Thank you Diane for all the work that

you do that helps promote recovery for individuals with serious mental illness. We are honored to have you represent San Francisco.

9. A New State of Mind: Ending the Stigma of Mental Illness

A New State of Mind: Ending the Stigma of Mental Illness is a documentary that aired on PBS May 30, 2013. Narrated by Glenn Close, this film tells the stories of everyday people through their struggles, recovery and resilience in the face of mental health challenges. It shines a light on the far-reaching effects of stigma related to mental illness. This documentary can be viewed at EachMindMatters.org.

10. Katie A. – San Francisco’s Plan

On March 4th and 5th a San Francisco Stakeholders group was assembled for a two-day summit, which involved system of care partners, community based organizations and peer families. Specific gaps were identified by the stakeholders with respect to: the availability of timely services for all foster-care youth; the capacity of the assessment process to reach all youth particularly those placed out of county; the quality and consistency of the services provided; and the involvement of youth and family at the policy and decision making level.

The group agreed on an AIM for Katie A. redesign:

Design an attachment and trauma focused system with a shared framework that is information driven, integrated, and innovative to support the health, safety, permanency and well-being of children, youth and families that have been involved in or at risk of involvement in Foster Care, Probation, Special Education and are struggling with the complications of behavioral health issues. The goal is to design a system that will serve the Katie A. and non-Katie A. children and families alike.

San Francisco plans to make significant enhancements to our current system of care. We will incorporate CPM, CFT, ICC, and IHB processes into all aspects of our service delivery system focusing on engaging children, youth and families from their first contact with the system and involving them in all aspects of their care. The SF plan involves building on our existing system by increasing our capacity to screen and assess, improve our quality and increase our coordinated care and in home capacity. We will work with providers and civil service clinics to develop and measure effective models to deliver these services.

With this large systems change goal in mind, San Francisco is well positioned to meet the specific needs of the class of children included in the Katie A. lawsuit. In 1996 San Francisco Community Behavioral Health and the Department of Human Services collaborated to create Foster Care Mental Health (FCMH). For seventeen years this program has assessed for medical necessity, authorized services and served the mental health needs of dependent children, youth and their families.

The service plan outlined below builds on this successful program by augmenting the assessment, treatment, quality and the available network for services. This redesign will increase coordination between mental health, social services and other agencies needed for individual children/youth and their families. It will assure comprehensive services are provided on a timely basis, and support

community-based delivery of those services. Improving the reach and effectiveness of FCMH will insure that the entire Katie A. class is served, as well as increase our focus on reaching foster care and at risk youth earlier in their involvement with social services with effective and comprehensive services. The Katie A. has been identified effectively in the context of a multiagency triage process referred as the Multi Agency Service Team (MAST), which began in 2009. Specific gaps were identified by the stakeholders with respect to: the availability of timely services for all foster-care youth; the capacity of the assessment process to reach all youth particularly those placed out of county; the quality and consistency of the services provided; and the involvement of youth and family at the policy, training and decision making level.

11. Substance Use Disorder

Two trainings related to opioid use and opioid use disorders were held in May. Both courses were star-studded with DPH faculty across disciplines and departments. On May 2nd was 'Pain Day', which drew over 300 participants from primary care and mental health clinics. This training, sponsored by the San Francisco Health Plan, focused on safety in use of opiates for chronic pain, and included speakers who addressed how to choose safe dose levels for patients who have pain, how to evaluate progress in treatment, how to taper off opioids, how to address addictive behaviors in patients who have pain, and included practice in motivational interview techniques. The day ended with clinic groups choosing improvement projects related to their pain treatment panels.

On May 15th, CBHS held an 8 - hour training on use of buprenorphine in office-based treatment of opioid dependence open to all DPH physicians. Out of those who attended, 27 physicians sent in notification of intent to prescribe buprenorphine, qualifying them for the federal waiver that enables buprenorphine use for addiction. Nurse practitioners also attended this training. Drug counseling, pharmacy and nursing were represented on the faculty, and Ramon Lacayo and Norman Aleman were in charge of logistics. One of the highlights of this course was a consumer advocate speaker, who was eloquent on how buprenorphine treatment at CBHS OBIC had helped her with her pain and her addiction.

12. Problem-Solving Courts

The San Francisco Superior Court has operated problem-solving courts (also known as collaborative courts) for almost two decades. Along with governmental (the Department of Public Health has been an active partner) and community-based partners, the courts strive to increase public safety by providing high quality, evidence-based services. Over the past 20 years, thousands of court-involved community members have participated in our programs and turned their lives around. To chronicle San Francisco's problem-solving courts, emerging trends in collaborative justice, and relevant news and research, the Court created a blog: [Moving Justice Forward](#).

We invite you to follow [Moving Justice Forward](#) and learn more about the problem-solving courts currently operating at the San Francisco Superior Court. Submit your email address by using the "Follow By Email" feature (upper right-hand corner of the homepage) to receive email updates whenever a new post is added to the blog. Please contact Lisa Lightman, Director of Collaborative Courts, if you have any questions.

13. Call for State Action – Andrea Shilton, CiMH

As some of you may have read, Senator Darrell Steinberg has released a “Call for State Action” regarding an increased investment in mental health services. I am attaching the proposal to this email. Late last week, more details of the proposal were released (see the attachment entitled “SBFR Handout for Investment in Mental Health Wellness”) but budget trailer bill language is not yet available. Consequently, the Pro Tem has additional time to finalize actual legislative language to implement the program. We do know the stated key objectives of the proposal are as follows:

- Add 25 Mobile Crisis Support Teams and at least 2,000 Crisis Stabilization and Crisis Residential Treatment beds over the next two years to expand community-based resources and capacity. These resources would provide a comprehensive continuum of services to address short-term crisis, acute needs, and the longer-term ongoing treatment and rehabilitation opportunities of adults with mental health care disorders.
- Add at least 600 triage personnel over the next two years to specifically assist several thousand high-need individuals to access medical, specialty mental health care, alcohol and drug treatment, social, educational and other services.
- Reduce unnecessary hospitalizations and inpatient days by appropriately utilizing community-based services and access to timely assistance.
- Reduce recidivism and mitigate unnecessary expenditures for local law enforcement.
- Emphasize early intervention and treatment to achieve recovery and reduce costs.
- Maximize federal funding opportunities, local realignment dollars, Proposition 63 Mental Health Services Act Funds (MHSA), foundation grant funds, and State General Fund monies.

Funding for the proposal would include \$142.5 million one-time state general funds; \$38.9 million MHSA state administration funds (largely from raising the current 3.5% administration cap back to its original 5%); and \$24.8 million federal funds.

Please pay particular attention to the line item in the Senate Budget and Fiscal Review attachment regarding *Peer Support Crisis Training*. The proposal would provide \$2 million in the area of training on topics such as crisis management, suicide prevention, recovery planning, targeted case management and related functions, and to facilitate employment of peer support classifications. The Office of Statewide Health Planning and Development (OSHPD) staff reported on this proposal to their Board of Trustees today, and indicated that they potentially would be administering these funds.

As more detail becomes available about this particular piece of the proposal, I will provide all of you with the statutory language and information (which could be as early as next week).

(See attachments 5 & 6).

14. California State University Launches On-Campus Programs for Veterans

The California State University system has launched a series of programs that serve veterans and help them achieve their new mission: obtaining a degree. Each campus has established a Veterans Resource Center to support veteran students. Trainings improve recognition of emotional distress

among veterans, and promote suicide prevention strategies for this population. Contact Ana Aguayo-Bryant at aaguayo@calstate.edu for more information.

15. Mental Health Loan Assumption Program

Receive up to \$10,000 in educational loan repayments.

Application deadline: October 1, 2013

For more information go to www.healthprofessions.ca.gov

(See attachment 7)

16. Collaborative Documentation – a Tool that Benefits Both Client and Staff

“When you write what I say, I feel heard, and I like knowing what goes in my chart.”

Several counties and states have been changing the way in which they document the session's content; it is called Collaborative Documentation. This type of documentation is a joint effort between a client and the service provider. The documentation is done in real time in the presence of the client and with the participation of the client. As clinical tool, it offers clients the opportunity to provide input and perspective on services and progress. It allows both the clinician and the client to clarify their understanding of important issues and goals. This process involves incorporating an active discussion at the end of the encounter and documenting the information into the EMR.

When the client's hand touches the door to leave the session, the documentation is complete. Collaborative Documentation is an appropriate extension of the therapeutic interaction that serves to focus the client on what just occurred in the session as well as their next steps in the process of their treatment/recovery. This type of documentation is reported to save an average of 6 – 9 hours per week in post-session documentation time.

A recent survey of clients showed that 81% (national average) found Collaborative Documentation to be helpful. They reported feeling validated -- what they say is “important”.

Community Behavioral Health Services is beginning to look at Collaborative Documentation. We will be asking for a few voluntary clinics that will learn with us as we begin this exploration. If you are interested, please contact Diane Prentiss (Diane.Prentiss@sfdph.org).

17. Transitioning to Primary Care

OMI Family Center has identified patient transitions to primary care as an important goal in a patient's wellness and recovery. To do this, we must focus on the possibility for the client to “graduate” from CBHS from the beginning of their treatment. However, transitioning our stabilized clients to primary care is a challenge for CBHS clinics. Barriers that are often faced by our CBHS providers are: clients without linkage to a primary care physician, a client's attachment to their CBHS clinic, the provider's attachment to their clients, and finally, the primary care provider's; hesitation, uneasiness with our client population, and fear of a client's decompensation, just to name a few. Regardless of these barriers, we don't want our clients to only identify themselves as mental health patients, instead we want them to focus on their strengths and road to recovery. To address some of these barriers, OMI Family Center has modified some of its clinic procedures.

OMI is currently changing its intake procedure for new clients to incorporate recovery as a goal for all patients. As a result, linkage to primary care will be a focus during the initial treatment sessions, rather than focused at the end stages of their treatment. This allows for both client and primary care provider to learn about one another, and to develop a comfortable relationship.

OMI's clinical pharmacist, Betsy Yuan PharmD, has developed a transition letter to send to primary care physicians that include pertinent information, such as: the client's DSM diagnosis, frequency of medication management appointments, frequency of therapy appointments, medication regimen, and recommended medication monitoring. The letter also indicates that the client has reached their treatment goals, extra refills of medications will be provided for a few months, and that the client's case will be left open for a year, in case the client needs to be seen again at OMI or the primary care provider needs to speak to the client's former specialist.

Over the past couple of years OMI's clinical pharmacist has had successful case transfers to primary care without any resistance from the primary care office or provider. As a result, OMI intends to formally integrate the clinical pharmacist into the final stages of a client's treatment. During this stage before "graduation", the clinical pharmacist also has the opportunity to fine tune and simplify a patient's medication regimen and empower the client with tools to improve their own treatment. Just one example, the pharmacist will review with clients the different methods to ensure they have medication refills in advance and ways to improve medication adherence. These final steps help to further prepare the client as they simultaneously step-up to a higher stage of recovery and step down to a lower intensity of mental health care. Thus, the services provided by the clinical pharmacist at OMI are an essential part to the patient's wellness, recovery and successful reintegration back into the community.

18. Journal of Public Health Devotes Entire May Issue to Mental Health Stigma - Pat Ryan, CMHDA

For the first time, the prestigious *American Journal of Public Health* (AJPH) devoted an entire issue in to the problem of mental illness stigma, framing it as a public health problem. The journal's May issue was several years in the making, thanks to hard work not only by the authors of the published papers and the *AJPH* staff, but by staff at the Carter Center and the Centers for Disease Control and Prevention (CDC). Several of the people involved in the effort, as well as those who have made great strides fighting stigma, celebrated the issue's launching at the Carter Center in Atlanta April 18. They included former First Lady Rosalynn Carter; Thomas Bornemann, Ed.D., director of the Carter Center Mental Health Program; Wayne Giles, M.D., director of the Division of Population Health at the CDC; Benjamin Druss, M.D., Rosalynn Carter, Chair of Mental Health at Emory University; Wayne Clark, PhD and Stephanie Welch, MSW, from the California Mental Health Services Authority (*CalMHSA*); and former member of Congress Tony Coelho, a major sponsor of the 1990 Americans With Disabilities Act. Stigma is scrutinized from many different vantage points in the new issue. One project entails identifying and eliminating existing laws, policies, and practices that result in discrimination against the mentally ill. Another project focuses on educating elementary school children about mental illness. Yet a third tries to remove scurrilous messages about people with mental illness from Spanish-language media. Of special note, CalMHSA's Stephanie Welch, MSW and Wayne Clark, PhD report in their article that California's 2004 Mental

Health Services Act (MHSA) is not only funding mental illness prevention and early-intervention strategies, but projects aimed at reducing mental illness stigma as well.

The special stigma issue received funding from the Carter Center, the CDC, and the Substance Abuse and Mental Health Services Administration. The issue can be accessed at <http://psychnews.psychiatryonline.org/newsarticle.aspx?articleid=1695389>.

19. Obama, Biden Headline White House-sponsored Conference on Mental Health- Pat Ryan, CMHDA

On Monday, National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD) Executive Director Ron Manderscheid was among those invited to the White House for the invitational National Conference on Mental Health hosted by President Obama and Vice President Biden. The event brought together people from across the country, including Capitol Hill leaders, mental health advocates, healthcare providers, representatives from state and local governments, educators, faith leaders, and individuals who have struggled with mental health problems "to discuss how we can all work together to reduce stigma and help the millions of Americans struggling with mental health problems recognize the importance of reaching out for assistance," according to the White House. The president provided extensive remarks about the importance of bringing mental health issues out of the shadows, and eliminating the stigma that too often discourages people from seeking help. "The main goal of this conference is not to start a conversation -- so many of you have spent decades waging long and lonely battles to be heard. Instead, it's about elevating that conversation to a national level and bringing mental illness out of the shadows. We want to let people living with mental health challenges know that they are not alone, and we've got to be making sure that we're committed to support those fellow Americans, because struggling with a mental illness or caring for someone who does can be isolating. And I think everybody here who's experienced the issue in one way or another understands that. It begins to feel as if not only are you alone, but that you shouldn't burden others with the challenge and the darkness, day in, day out -- what some call a cloud that you just can't seem to escape -- begins to close in."

The national "Call to Action to Create Community Solutions on Mental Health" will include an ongoing national dialogue to be co-chaired by Health and Human Services Secretary Kathleen Sebelius and Education Secretary Arne Duncan. The Administration has launched a website at www.mentalhealth.gov to provide a single portal for information and resources for the national dialogue. With the tag line of "Let's Talk About It," the site includes information for consumers, educators, and others. The Department of Veterans Affairs has also announced plans to convene local mental health summits with community partners to help address the needs of veterans and their families. Finally, a California "Call to Action" forum has been scheduled for Saturday, July 20, from 9:30 am to 3:30 pm in Sacramento at the Sacramento Convention Center (1400 J Street). To register, go to www.creatingcommunitysolutions.org and click on the Sacramento button on the map.

20. Wellness and Recovery – Gloria Frederico, MFT

Opportunities for Wellness and Recovery can happen at any time. It is often these unexpected moments of kindness that can have the greatest impact on our clients. I would like to share with you one such moment that I learned about while attending the OMI Family Center Staff Retreat.

The purpose of the retreat was to introduce the strengths based treatment and wellness and recovery best practices that were learned during Team OMI's participation in the Advancing Recovery Practices learning collaborative sponsored by California Institute of Mental Health.

The Staff Meetings at OMI Family Center start with the leadership team asking staff to share any recent client successes or even recent successes in their own life. Each and every success reported is met with enthusiastic applause. Success stories were shared by clinical staff, medical staff and even one from the Deputy Sheriff. It is Deputy OT Cotton's which I will share with you now.

Deputy Cotton has been stationed at OMI Family Center for fourteen years. His desk is located next to the waiting area where children and teenagers wait until they are seen by their treating clinician. Deputy Cotton observed a 12 year old boy who often sat with his face covered and ignored any attempts at engagement by clerical or clinical staff. Deputy Cotton observed this behavior for many weeks until finally he asked the boy to please sit up straight and to answer questions when addressed by staff.

Deputy Cotton then began to ask the boy how he was doing in school and if he liked video games. A conversation ensued and a relationship was formed. It eventually came out that this youth was at risk of not graduating from the eighth grade. After checking with the boy's father, Deputy Cotton made the boy a deal: If he could get a grade "C" or better in all of his classes then Deputy Cotton would bring him in a video game at the end of the year.

Many months passed and the changes that were occurring within the boy could be seen by all. The young boy was sitting up straight, with no hoodie covering his face, and was engaging in conversation with Deputy Cotton and other staff who sat nearby. The transformation was slow but steady.

In early June this young man came to the clinic with his diploma in hand. He asked if Deputy Cotton could please make a copy of his Diploma. A copy was made and then the young boy said, "You forgot a very important person." Deputy Cotton said, "I did. Who?" The young man responded, "You."

When Deputy Cotton shared this story there was not a dry eye in the room.

21. NAMI California is looking for Ending the Silence Presenters

NAMI California is seeking presenters to participate in an educational program designed for high school audiences. Through a PowerPoint, short videos, and personal testimony, students learn symptoms and indicators of mental illness, as well as how to help themselves or others who may be in need of support. Young adults (18-29) with lived experience are particularly encouraged to apply. Upcoming two-hour webinar trainings will be offered on June 12th and June 27th. If you are interested, please contact Beth Larkins at beth.larkins@namicalifornia.org.

22. MHSA Annual Report

San Francisco Mental Health Services Act Annual Report for FY 2012/2013 is now available to review and comment on the SF DPH website at:

<http://www.sfdph.org/dph/comupg/oservices/mentalHlth/MHSA/mnu30-DayNotice.asp>

The Community Behavioral Health Services (CBHS) unit of the Department of Public Health is inviting all stakeholders to review and comment on the San Francisco Mental Health Services Act Fiscal Year 2012-2013 Annual Report for a period of 30 days from June 11, 2013 to July 10, 2012. This 30-day stakeholder review and comment is in fulfillment of the provisions of the Welfare and Institutions

(W&I)	Code	Section	5848.
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Please email your comments to Marlo.Simmons@sfdph.org or send by mail to:

Community Behavioral Health Services Mental Health Services Act
1380 Howard Street, Room 210b
San Francisco, CA 94103

Past issues of the CBHS Monthly Director's Report are available at:

<http://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSdirRpts.asp>

To receive this Monthly Report via e-mail, please e-mail reanna.albert@sfdph.org

1.2 Public Comment

No public comment.

ITEM 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Updates

Ms. Robinson said the MHSA annual report is posted for a 30 day review prior to the Health commission meeting and the review by the Mental Health Board.

2.2 Public comment

Ms. Crystal wanted to know about health home care and services for San Francisco

Ms. Robinson said they are still researching right now.

ITEM 3.0 ACTION ITEMS

Mr. Joseph said, in addition to approval of minutes for the May Board Meeting, the board will be voting on a Budget Resolution proposed by the Executive Committee.

3.1 Public comment

No public comments.

3.2 PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of May 8, 2013 be approved as submitted.

Unanimously approved

3.3 PROPOSED RESOLUTION (MBH 2013 –03)

That the Mental Health Board thanks the Mayor and Board of Supervisors for supporting and recognizing the importance and value of mental health and substance abuse services in the 2013-14 Budget Allocations.

Unanimously approved

ITEM 4.0 PRESENTATION: MENTAL HEALTH BOARD ROLES AND RESPONSIBILITIES, CARY MARTIN, PRESIDENT, CALIFORNIA ASSOCIATION OF LOCAL MENTAL HEALTH BOARDS AND COMMISSIONS (CALMHBC)

Mr. Joseph introduced Cary Martin, President of the California Association of Local Mental Health Boards and Commissions for the State of California to give an overview of the roles and responsibilities of board members.

4.1: Presentation: Mental Health Board Roles and Responsibilities, Cary Martin, President, California Association of Local Mental Health Boards and Commissions (CALMHBC)

Mr. Martin is currently Chair of the California Association of Local Mental Health Boards. In the 1960's, he lived in San Francisco and worked at Langley Porter, where he actively piloted several behavioral health programs.

He briefly talked about the history of mental health in California under Governor Ronald Reagan. During this time period, there were a couple of important tsunami changes in psychiatry. Not wanting to continue the mental hygiene movement, Governor Ronald Reagan vetoed important but necessary mental healthcare services and programs, and many Californians were adversely affected by these changes. Additionally, people with mental illness were de-institutionalized from hospitals without any care safety net. Suddenly, communities were seeing a big wave of people with mental illness in their communities. Also, homelessness became a huge problem. But Republican Senator

Milton Marx tried to stem the hemorrhage in mental health services and programs. He changed his votes to turn the tide and saved some behavioral health programs.

He said that prior to Governor Reagan the words hobos, winos and homelessness were not viewed with derision as they are today. Before the 1950's, these words elicited compassion. [*Probably, 1920's Depression Era, the Dust Bowl of the 1930s and the two World Wars, just about every family in America were personally touched either by tragedies, hardship and/or destitution.*]

He talked about mental health board duties and responsibilities. In the §5604.2 of the California Welfare and Institutional Codes (WICs), He said "the local mental health board shall do ..." review of the community's mental health needs, services, facilities and special problems.

Dr. David Elliott Lewis paraphrased that §5604.2 has a mandate for the Mental Health Board of San Francisco to perform program reviews annually.

Ms. Robinson stated that she found the board's summaries of program reviews to be very important and helpful.

Mr. Martin emphasized the importance of prevention as stated in the §5608 (c). He believed that if a client/patient received a mental health diagnosis then prevention has already failed. He personally believed that not enough is being done around prevention in many counties in California. MHSA would provide resources to meet unmet needs.

His second emphasis was § 5650. Local mental health boards are obligated to review contracts for services and programs as stated in §5650 (3) before the Board of Supervisors (BOS).

He believed that the board needs to advise directors about any aspect of mental health programs. For example, in January 2005 he traveled throughout the State of California to have dialogues with county leaders. He encouraged board members to look for ways to do outreach and keep constituents abreast of mental health related issues.

Ms. Bohrer asked about interaction among different counties' mental health boards.

Mr. Martin said there is some collaboration but not as much as he expected.

Ms. Bohrer asked if the majority of counties merged substance abuse and mental health boards together.

Mr. Martin replied that there has always been a division between mental health and substance abuse. He personally does not like the term behavioral health.

Dr. David Elliott Lewis asked why Mr. Martin does not like the words behavioral health

Mr. Martin explained the term behavioral health does not really capture the essence of mental health and substance abuse.

4.2 Public Comment

No public comments.

ITEM 5.0 REPORTS

For discussion

5.1 Report from the Executive Director of the Mental Health Board.

Ms. Brooke made the following announcements:

1. Beilenson Hearing on Tuesday, June 18th, 2013 at 3:00 pm at City Hall, Board of Supervisors chamber.
2. Very successful first forum on May 22nd, 2013 titled "Path To Wellness" with LaVaughn Kellum King facilitating the panel of Dr. Charles Wibbelsman, Chief of Adolescent Medicine for Kaiser, Dr. Emily De La Rosa, Clinical Social Worker for Kaiser, Jeff Steinberg, Founder of Sojourn to the Past, and Laurie Marshall of the Create Peace Project. The food was great and presentations fabulous. Virginia Lewis was there from the board. The next forum is July 17th, 2013.
3. Attachment Theory and Trauma Conference Thursday June 27th, 2013 in Oakland
4. Presentation of the Health Care Services Master Plan on Thursday, July 11th 2013 at 101 Grove, Room 300, at 4:00 pm
5. July 18, 2013 is Mental Health in the SF Bay Area by KTVU TV at 2 Jack London Square 1:15-4:00. Lunch will be served.
6. Consumer and Family Conference Friday, July 19th, 2013. Lunch will be served.
7. Issues to Action July 20th, 2013 6:15 – 8:30 pm

5.2 Report from the Chair of the Mental Health Board and the Executive Committee.

Mr. Joseph shared that Alyssa Landy is resigning her seat on the board due to conflicts with scheduling from her job.

Also, he invited board members to attend the next Executive Committee meeting on Thursday, June 20th at 6:30 at 1380 Howard Street, Room 515. All board members are welcome to attend the meeting as well as members of the public.

5.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

Sgt Kruger nominated Cecile O'Connor and Dr. Melissa Nau at PES (Psychiatric Emergency Services.)

5.4 Report by members of the Board on their activities on behalf of the Board.

Ms. Virginia Lewis along with several other members from the Physicians Organizing Committee and San Francisco Cares visited Senator Leland Yee's office to discuss Sutter CPMC's breach of contract to provide psychiatric beds for San Francisco.

Dr. David Elliott Lewis also visited Senator Yee's office. He said that San Francisco Housing and Health Care Justice has been lobbying for Sutter CPMC to keep its promise. He believed that Sutter CPMC needs oversight transparency and penalties for any non-compliance.

Sgt Kruger mentioned that the next CIT (Crisis Intervention Training) training will be from June 17th to 20th, 2013 starting at 8 AM at the County Fair Building at 9th and Lincoln. She welcomed observation from board members, but requested board member to have no interaction with presenters.

5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

Mr. Joseph announced that most board members attended the December 2013 Board Retreat and gave direction to the Executive Committee, but this item is a place where they can suggest things to the Executive Committee for future Mental Health Board meetings. He asked if there any members of the board who have any suggestions for the Executive Committee for future agenda items. He also reminded everyone that a brief statement describing the item is all that can be said, and there can be no board discussion on the new item, since it has not been noticed to the public yet.

Dr. David Elliott Lewis would like Colleen Chawla who is the Deputy Director of Health and Director of Policy and Planning of San Francisco Department of Public Health to come and talk about the Affordable Care Act.

5.6 Public comment.

Ms. Crystal talked about Family Service Agencies and a few others that are funded by MHSA. She proposed hearing about the Prevention & Recovery in Early Psychosis (PREP) program for adolescents.

Mr. Martin suggested a presentation with data to be interpreted to the Board of Supervisors.

ITEM 6.0 PUBLIC COMMENT

No public comments.

ADJOURNMENT

Meeting adjourned at 8:34 PM.

Corv Martin WJC document

5601. As used in this part:

(a) "Governing body" means the county board of supervisors or

boards of supervisors in the case of counties acting jointly; and in the case of a city, the city council or city councils acting jointly.

5602. The board of supervisors of every county,..... shall establish a community mental health service to cover the entire area of the county

5604. (a) (1) Each community mental health service shall have a mental health board consisting of 10 to 15 members

Nothing in this section shall be construed to limit the ability of the governing body to increase the number of members above 15. Local mental health boards may recommend appointees to the county supervisors. Counties are encouraged to appoint individuals who have experience and knowledge of the mental health system. The board membership should reflect the ethnic diversity of the client population in the county.

(2) Fifty percent of the board membership shall be consumers or the parents, spouses, siblings, or adult children of consumers, who are receiving or have received mental health services. At least 20 percent of the total membership shall be consumers, and at least 20 percent shall be families of consumers.

(b) The term of each member of the board shall be for three years. The governing body shall equitably stagger the appointments so that approximately one-third of the appointments expire in each year.

(d) No member of the board or his or her spouse shall be a full-time or part-time county employee of a county mental health service, an employee of the State Department of Health Care Services, or an employee of, or a paid member of the governing body of, a mental health contract agency.

(e) Members of the board shall abstain from voting on any issue in which the member has a financial interest as defined in Section 87103 of the Government Code.

(g) The mental health board may be established as an advisory board or a commission, depending on the preference of the county.

5604.2. (a) The **local mental health board** shall do all of the following:

(1) **Review and evaluate the community's mental health needs, services, facilities, and special problems.**

(2) **Review any county agreements entered into pursuant to Section 5650.**

(3) **Advise the governing body and the local mental health director**

as to any aspect of the local mental health program.

(4) Review and approve the procedures used to ensure citizen and professional involvement at all stages of the planning process.

(5) Submit an annual report to the governing body on the needs and performance of the county's mental health system.

(6) Review and make recommendations on applicants for the appointment of a local director of mental health services. The board shall be included in the selection process prior to the vote of the governing body.

(7) Review and comment on the county's performance outcome data and communicate its findings to the California Mental Health Planning Council.

(8) Nothing in this part shall be construed to limit the ability of the governing body to transfer additional duties or authority to a mental health board.

(b) It is the intent of the Legislature that, as part of its duties pursuant to subdivision (a), the board shall assess the impact of the realignment of services from the state to the county, on services delivered to clients *and on the local community*.

5604.3. The board of supervisors may pay... necessary expenses...of their official duties and functions.-- include travel, lodging, child care, and meals.. approved by the director of local mental health program.

5604.5. The local mental health board **shall develop bylaws** to be approved by the governing body which shall:

(a) **Establish the specific number of members** on the mental health board, consistent with subdivision (a) of Section 5604.

(b) **Ensure** that the composition of the mental health board represents the **demographics of the county** as a whole, to the extent feasible.

(c) **Establish** that a **quorum** be **one person more than one-half of the appointed members**.

(d) **Establish** that the **chairperson** of the mental health board be **in consultation with the local mental health director**.

(e) **Establish** that there may be an **executive committee** of the mental health board.

5607. The local mental health services.. director.. appointed by.. governing body

5608. The local **director** of mental health services.. **shall..**

(c) **Recommend to the governing body, after consultation with the advisory board, the provision of services, establishment of facilities, contracting for services or facilities and other matters necessary or desirable in accomplishing the purposes of this division.**

(e) **Carry on studies** appropriate for the discharge of his or her duties, including the control and prevention of mental disorders.

(f) Possess authority to **enter** into negotiations for contracts or agreements for the purpose of providing mental health services in the county.

What are State Mental Health Planning and Advisory Councils?

In 1986, a Federal law was passed that required states to do mental health planning as a condition of receiving federal mental health funds. It further required that the planning process include various stakeholder groups—consumers of mental health services, parents of children with emotional disturbances, family members of adults with serious mental illness, representatives from State agencies: mental health, education, vocational rehabilitation, criminal justice, housing, social services and the state Medicaid agency as well as public and private entities concerned with the need, planning, operation, funding, and use of mental health services and related support services. U.S. States and Territories then formed these councils which now exist in every state.

What do these councils do?

The purpose of the planning councils in each State and Territory is to meaningfully involve concerned citizens in planning and evaluating the mental health service delivery in their states. Defined by Federal law, these councils:

- Review community mental health block grant plans and make recommendations to the State administration.
- Monitor, review and evaluate all mental health services throughout the State or Territory.
- Serve as advocates for adults with serious mental illnesses, children with severe emotional disturbances, and others with mental health needs.



the 1990s, the number of people in the UK who are aged 65 and over has increased from 10.5 million to 12.5 million, and the number of people aged 75 and over has increased from 4.5 million to 6.5 million (Office for National Statistics 2000).

There is a growing awareness of the need to address the needs of older people in the community. The Department of Health (1999) has published a strategy for older people, which sets out the government's commitment to older people and the actions that will be taken to improve their lives. The strategy is based on the principle that older people should be able to live independently and actively in the community, and that they should be able to participate in the decisions that affect their lives. The strategy sets out a range of actions that will be taken to improve the lives of older people, including: improving the quality of care and support for older people; increasing the number of people who are able to live independently in the community; and improving the opportunities for older people to participate in the decisions that affect their lives.

The strategy also sets out a range of actions that will be taken to improve the lives of older people in the community, including: improving the quality of care and support for older people; increasing the number of people who are able to live independently in the community; and improving the opportunities for older people to participate in the decisions that affect their lives. The strategy is based on the principle that older people should be able to live independently and actively in the community, and that they should be able to participate in the decisions that affect their lives.

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SAN FRANCISCO MENTAL HEALTH BOARD

Mayor Edwin Lee

1380 Howard Street, 2nd Floor
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@mhbsf.org
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www.sfgov.org/mental_health

MEETING OF THE MENTAL HEALTH BOARD

Wednesday, July 10, 2013

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

6:30 PM - 8:30 PM

CALL TO ORDER

ROLL CALL

AGENDA CHANGES

Item 1.0 DIRECTORS REPORT

For discussion.

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public Comment

Item 2.0 MENTAL HEALTH BOARD ACKNOWLEDGEMENTS: Cecile O'Connor, Dore Urgent Care, Melissa Nau, MD, San Francisco General Hospital Psychiatric Emergency Services (PES) Director

Item 3.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

For discussion.

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

3.1 Mental Health Services Act Updates: Mental Health Services Act Annual Update, Marlo Simmons, Director

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3.2 Public Comment

Item 4.0 ACTION ITEMS

For discussion and action.

4.1 Public comment

4.2 PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of June 12, 2013 be approved as submitted.

4.3 PROPOSED RESOLUTION: Be it resolved that the Mental Health Board will not meet in the month of August 2013.

Item 5.0 REPORTS

For discussion

5.1 Report from the Executive Director of the Mental Health Board.
Discussion regarding upcoming events, conferences, or activities that may be of interest to board members; Mental Health Board budget issues and update on staff work on board projects.

5.2 Report of the Co-Chairs of the Board and the Executive Committee.
Discussion regarding Chair's meetings with Community Behavioral Health Services staff, meetings with members of the Board of Supervisors and community meetings about mental health or substance abuse.

5.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

5.4 Report by members of the Board on their activities on behalf of the Board.

5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

5.6 Public comment.

6.0 PUBLIC COMMENT

ADJOURNMENT

DISABILITY ACCESS

1. Room 278 is accessible to persons using wheelchairs and others with disabilities. Assistive listening devices, materials in other alternative formats, American Sign Language interpreters and other accommodations will be made available upon request. Please contact Darlene Daevu, Community Behavioral Health Services, 415-255-3426 or by email: Darlene.daevu@sfdph.org. Providing at least 72 hours notice will help to ensure availability. To reach a TTY line, call (415) 255-3449. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at City Hall, One Dr. Carlton B. Goodlett Place (between Grove and McAllister), in Room 278. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 71 Haight/Noriega. Also, the J, K, L, M, and N lines underground. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. Special Hearings are usually held at the Department of Public Health, 101 Grove Street, 3rd Floor, Room 300. The same public transportation options as above apply. It is wheelchair accessible.

4. For Special Hearings at other locations, please call for directions or bus information. All locations will be accessible.

5. City Hall is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on One Dr. Carlton B. Goodlett Place.

6. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES

The ringing of and use of cell phones, pagers, and similar sound-producing electronic devices are prohibited at this meeting. Please be advised that the Chair may order the removal from the meeting room of any person(s) responsible for the ringing or use of a cell phone, pager, or other similar sound-producing electronic devices.

KNOW YOUR RIGHTS UNDER THE SUNSHINE ORDINANCE

Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415) 554-7724
Fax: 4(15) 554-5163
E-mail: sotf@sfgov.org

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from the Task Force or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: www.sfgov.org/sunshine

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: www.sfgov.org/mental_health. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

Lobbyist Registration and Reporting Requirements

Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics

SAN FRANCISCO MENTAL HEALTH BOARD



Edwin Lee
Mayor

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Unadopted Minutes

Mental Health Board

Wednesday, July 10, 2013

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

San Francisco, CA

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BOARD MEMBERS PRESENT: Ellis Joseph, MBA, Co Chair; David Elliott Lewis, Ph D, Co Chair; Wendy James, Vice Chair; Virginia S. Lewis, MA, LCSW, Secretary; Terry Bohrer, RN, MSW, CLNC; Kara Chien, JD; ; Sgt. Kelly Kruger; Lena Miller, MSW; Terence Patterson, EdD, ABPP; Alphonse Vinh, MS.

BOARD MEMBERS ON LEAVE: Marlene Flores; Errol Wishom.

BOARD MEMBERS ABSENT: Melody Daniel, MFT

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jo Robinson, Director of Community Behavioral Health Services (CBHS); Marlo Simmons; Rhea Bailey, MPH; Wendy Yu; Toni Parks and two members of the public.

CALL TO ORDER

Mr. Joseph called the meeting of the Mental Health Board to order at 6:45 PM.

ROLL CALL

Ms. Brooke called the roll.

AGENDA CHANGES

There were no changes to the agenda.

ITEM 1.0 DIRECTOR'S REPORT

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

Ms. Robinson highlighted the following items which are included in the July Director's report.

She reported that the FY 2013-14 budget for the Department of Public Health (DPH) is complete, and there was some more money added for the department.

Moments after the Asiana flight 214 crash on Saturday July 6th, 2013, she immediately went to San Francisco International Airport. Also, at the same time, other DPH officials were within minutes at the airport as well to quickly respond to the victims of the disastrous flight which was full of 15-17 years old Chinese students and Korean passengers.

In the first hours of breaking news, there was a convergence of the San Francisco Emergency Disaster team, DPH and CBO volunteers with disaster training to help out at the airport. CBHS deployed 17 Cantonese, Mandarin and Korean speaking mental health specialists who were there until 1 AM on Sunday. Every day since the incident, CBHS mental health therapists have been available to everyone to address the trauma.

For example, passengers needed anxiolytic to reduce anxiety for returning flights to their home countries. For those passengers whose medications were consumed in the inferno, their prescriptions were quickly refilled by doctors. There were lots of first-time away from home 15-17 year old students who had put their money in their suite cases, which they had no access to as everyone was trying to evacuate the plane. Provision for emergency money was made to get them through a few days.

Dr. Patterson inquired about food provision for the Asiana flight 214 victims.

Ms. Robinson explained that upon the final approach to SFO, the crash occurred at 11:04 a.m. According to survivors and rescuing staff, United Airlines, Asiana's partner in Star Alliance, did not urgently coordinate food services. Victims of the crash reported that they were denied access to food, and eventually they got food after 10 PM that day. She emphasized that many students were victims of the crash.

Although Subway was contracted to provide sandwiches to the victims, the company seemed to be more of a hindrance than helpful. Subway was very slow at responding to the plight of the victims, despite pleading from officials.

Dr. David Elliott Lewis asked what operational weaknesses came out during debriefing.

Ms. Robinson stated that as a part of disaster planning for the future, they should include on-call psychiatrists and phone chargers. Being told to leave all their personal belongings behind during the evacuation from the inferno, passengers were only able to take their cell phones with them as they scrambled out of emergency exits.

She mentioned other issues that need to be addressed with Red Cross officials.

For example, when the surviving high school students regrouped right after evacuation, they realized that their two friends were unaccountable for. In the immediacy, the students were instinctively concerned and wanted to find their missing friends. So they reached out to authorities for help.

But the authorities would not respond to their requests about their friends fates because they had not notified the students' parents or next of kin yet, which is a federal regulation. Most students were

very upset with the authorities because the students were left feeling exasperated and kept guessing about what happened to their friends as they stood by helplessly wondering if they had abandoned their missing friends whom may have been succumbed alive in the inferno. An extra layer of trauma was added because their survivor guilt kicked in.

Another example is the survivors, of which many of them were just high school students, were not allowed access to psychiatric first aid professionals. The FBI and United Airlines investigators sequestered the victims from having any contact with CBHS clinicians and therapists in order to obtain eye-witness accounts of the crash.

Ms. Bohrer: She mentioned that she was very impressed with Mayor Ed Lee's response to the incident and wondered if there is there any way the board can recognized the volunteers.

Ms. Robinson stated that she would get the list of the volunteers.

1.2 Public Comment

No public comment.

Monthly Director's Report **July 2013**

1. CBHS and SFGH Respond to SFO Plane Crash Disaster

Seventeen members of a CBHS mental health disaster emergency response team rushed to San Francisco International Airport on Saturday July 6 to provide counseling, reassurance and comfort to the passengers of the Asiana jet liner that crash landed at San Francisco International Airport. In the days following, CBHS continued to provide disaster mental health assistance to the passengers and their families at the assistance center in Burlingame that was established by the National Transportation Safety Board, United/Asiana Airlines, and the Red Cross. In particular, a good number of CBHS counselors who were fluent in the Korean and Mandarin languages were able to deploy to support the victims.

CBHS extends sincere gratitude to each and everyone who helped respond to the disaster mental health needs of the passengers of the Asiana flight, and their families. Counselors and program managers from Comprehensive Crisis Services, Sunset, RAMS, Citywide Case Management, Central City Older Adults, South of Market, OMI and Mission Mental Health clinics, and from the Chinatown Public Health Center, all assisted in the disaster mental health response. Thank you to all dropped everything at a moment's notice, and worked long hours and stayed late into the night at SFO and at the assistance center, providing support to all who were affected by the disaster.

Dozens of volunteers throughout the San Francisco Department of Public Health also showed up to help. Much of the activity and response occurred at San Francisco General Hospital where the trauma team, medical and support staff tended to 53 of the crash victims. Edward Chow, MD, Vice President of the San Francisco Health Commission, thanked and commended DPH employees and contractors for their "excellent and professional response."

Meanwhile, San Francisco DPH has announced that mental health counseling services are available to anyone who witnessed or was deeply affected by the incident. Many people were on the ground

when the incident happened and witnessed the tragedy--some as travelers, others as workers, staff and responders. CBHS is encouraging anyone who feels a need to talk to a counselor to call 3-1-1 and ask for mental health counseling. The services will continue for as long as needed.

2. Licensed Mental Health Services Provider Education Program and Mental Health Loan Assumption Program

Below are descriptions of two financial incentive programs for qualified mental health providers to repay their educational loans.

Licensed Mental Health Services Provider Education program. This program is for psychologists, postdoctoral psychological assistants, postdoctoral psychological trainees, clinical social workers and marriage & family therapists who have unrestricted licenses, registrations or waivers. Awardees can receive **up to \$15,000** in educational loan repayments; and the aforementioned roles must work or intern in a qualified facility providing direct patient care for a minimum of 32 hours per work for 24 months. The FY13-14 application cycle opens on July 1, 2013 on CalREACH and applications are due by October 1, 2013. For full details visit www.healthprofessions.ca.gov

Mental Health Loan Assumption Program. This program encourages mental health providers to practice in underserved California locations in designated hard-to-fill/retain positions. Awardees can receive **up to \$10,000** in educational loan repayments. Eligible applicants must work or volunteer in the public mental health system for at least 20 hours per week, may not have another service obligation commitment from June 2014 to June 2015 and have a commercial or government educational loan that needs to be repaid. The FY13-14 application cycle open on July 1, 2013 on CalREACH and applications are due by October 1, 2013. For full details visit www.healthprofessions.ca.gov

3. Emerging Drug Trends 2013: Beyond Synthetics and Bath Salts

Date & Time: Wednesday, July 24, 2013, 1:00 PM EDT, 12:00 PM CDT

Speakers:

Ken Dickinson, MS, RHP, Director of Marketing
Gaudenzia Treatment Center

Join this webinar and get a brief review of the current trends associated with the synthetic drugs known as "Bath Salts" and the "Synthetic Cannabinoids." The focus will be on introducing and discussing newer emerging substances, some of which are being promoted as alternatives to K2/Spice and Bath Salts.

Some of the trends to be discussed include the increase in usage of Kratom, an unregulated leaf, and the re-emergence of hallucinogens such as DMT and 2 C1, as well as other compounds emerging from chemists in Europe.

Learning Objectives:

- Learn about emerging drug and synthetic drug trends while identifying resources that help participants to stay current and possibly ahead of the curve.

- List the desired effects as well as mental, emotional, behavioral, physical, toxic, and withdrawal effects associated with these emerging drugs.
- Learn about the latest developments in drug testing and how to take advantage of new technology in drug testing.

For more information regarding Continuing Education Credit for this program, go to:

http://www.behavioral.net/webinar/emerging-drug-trends-2013-beyond-synthetics-and-bath-salts?WA_MAILINGLEVEL_CODE=&spMailingID=41958438&spUserID=NTA3NTMzOTk5MzAS1&spJobID=193592360&spReportId=MTkzNTkyMzYwS0#CEInformation

Can't attend? Register anyway and get full access to the on-demand presentation and slides. If you have any questions, please email webinars@vendomegrp.com

4. **Tobacco Sales to Youth Slip** – an article from SFGate.com

Fewer youths are buying tobacco in San Francisco. Illegal sales of tobacco to youngsters was down more than two percent between June 2011 and June 2013, according to figures released Tuesday by the San Francisco Department of Public Health.

Much of the decline can be attributed to rigorous enforcement, including sting operations by the San Francisco Police Department, and a robust education program designed to alert retailers to the potential consequences of selling tobacco products to young people, according to health plan coordinator Derek Smith.

Of the 1,016 licensed tobacco retailers in the city, 454 were the target of sting operations during this period. Police issued 61 citations to stores willing to sell tobacco products to 16- and 17-year-old decoys who could not produce identification.

Retailers caught selling tobacco products to minors can have their permits revoked for 25-30 days and the individuals responsible for the sale can be ticketed and fined.

While the dip in scofflaw merchants is encouraging, the city still has a rate of illegal tobacco sales nearly five percentage points higher than the state average. Of the retailers visited by police in San Francisco decoys, 13.4 percent sold tobacco to the undercover decoys. Statewide, that number drops to 8.7 percent.

The high rate is likely due to the fact that San Francisco is a small city with high population density and large concentrations of tobacco retailers in low-income neighborhoods like the Tenderloin and Hunter's Point, Smith said.

Research conducted by the Tobacco Use Reduction Force, a group of seven young people who each represent a different neighborhood, found that of the more than 1000 tobacco retailers in the city, 517 were located in just three of the eleven districts, all with a lower than average median income.

"These high concentrations normalize the use of tobacco in disadvantaged communities," said Avni Desai, program coordinator at the Youth Leadership Institute, which runs the TURF program. "It creates a health disparity."

5. RAMS Peer Specialist Mental Health Certificate Program is Accepting Fall 2013 Applications

RAMS, in collaboration with SFSU, is excited to announce that the Peer Specialist Mental Health Certificate Program is currently accepting applications for the Fall 2013 Class!

Funded by the Mental Health Services Act (MHSA), the Peer Specialist Mental Health Certificate Program provides a 12-week long training for consumers of behavioral health services or family members who are interested in becoming peer counselors/peer specialists in the field of community behavioral health.

We are looking for individuals who are:

- at least 18 years old
- residents of San Francisco
- have completed at least a high school level education or GED
- current or past consumers of behavioral health services and/or family members
- interested in helping others in the community behavioral health setting

Application and course timeline is as follows:

Monday, July 1st - Application Release

Tuesday, July 16th - Optional Program Open House (see attached flyer for details)

Friday, August 9th @ 5:00pm - Application Deadline

Week of August 26th - Notification of Application Status

Friday, September 6th - Registration Forms Due for accepted applicants

Tuesday, September 17th, - 1st Day of Class

Tuesday, December 17th, - Last Day of Class

Attached are the program brochure, open house flyer, and application form. Kindly distribute this to those in your network and your consumer community, as applicable. Please feel free to contact Program Coordinator, Christine Tam, MA, LCSW at (415) 668-5955 x386 or christinehtam@ramsinc.org should you have any questions. Materials are also available for download at: <http://ramsinc.org/peerspecialistmhcert.php>

We look forward to receiving the applications, Fall 2013 class, and beginning another great cohort!

(See attachments 1, 2, 3)

6. Consumer and Family Conference: Food, Mood & Move

July 19, 2013

10am-2pm

St. Mary's Cathedral Conference Center

1111 Gough Street

Speakers:

Laura Brainin-Rodriguez MPH, MS, RD

Coordinator, Feeling Good Project

SF Department of Public Health, Nutrition Services

Chloe Yu BA, BS, RD and Erica Eilenberg, MPH(c)

Feeling Good Project

SF Department of Public Health, Nutrition Services

Carmen Bogan MBA

Physical Activity Coordinator

Network for a Healthy California Bay Area Region

Providing nutrition and physical activity education as part of mental health and substance abuse services poses particular challenges for mental/behavioral health and recovery service providers. This may be due to lack of knowledge on the part of providers or difficulty figuring out how to integrate this information into service delivery. In addition low income diverse populations may face difficulties in accessing healthy foods and opportunities to be physically active due to a lack of resources in their communities.

The purpose of this workshop is to provide training on what constitutes healthy eating, how to assist clients in assessing their overall diet quality, tips and resources on how to eat healthy on a budget and how to reduce intake of foods and beverages of low nutritional value. It will also give providers an opportunity to become familiar with simple low cost ways to promote physical activity to their clients as a way to improve their physical and mental health. The course will be taught at an intermediate level, and is appropriate for currently licensed professionals and current recovery service providers, as well as those working in primary care settings.

7. Iraqi Refugees Support Group

This year MHSA has begun funding the Arab Cultural and Community Center (ACCC) of San Francisco (www.arabculturalcenter.org) to provide **culturally sensitive mental health support to Iraqi refugee females** who are struggling with severe depression, anxiety and isolation. Since the start of the war in Iraq, tens of thousands of refugees have been resettled in the US and almost 14,000 in California. The Bay Area has seen a dramatic influx of refugees these past five years, mainly from Iraq and more recently a few from Syria. Many of these refugees are suffering from extreme symptoms associated with the traumas of war and relocation.

One Iraqi refugee mother who called the ACCC said, "I feel very depressed as I lost everything in Iraq. I often just want to stay in bed as I have no reason to get up. I live in a dangerous neighborhood where I don't know any of my neighbors. I don't know any other refugees here as we were resettled far from each other. I have a college degree from Iraq but don't even know how to take the bus here! I am so isolated and lonely."

In Iraq and other countries in the Arab world, receiving mental health services often carries a negative stigma for the client. Many clients are afraid of seeking mental health services as they will be stigmatized by their community as being crazy. Some clients worry that this could affect their

chances of marriage and/or chances of marriage for their children as it may be construed that the therapist is dealing with a problem that might be genetic and thus can be inherited.

The support group aims to provide a space where refugee women can receive mental health support within a culturally acceptable channel without the worry of acquiring the stigma associated with going to see a therapist. The support group is a safe place for the women to bond with each other, share with each other, cook together, and learn essential life skills together. It provides a place where they can learn about topics such as depression, PTSD, health and wellness in a supportive environment. This support group is also a safe space where women can seek help confidentially about mental health services and other needed health referrals.

8. CBHS Conflict of Interest Policy for interactions with the Pharmaceutical Industry

Community Behavioral Health Services (CBHS) strives to provide quality, evidence-based client care, and create a treatment environment that is free from the undue influence of the pharmaceutical industry. The CBHS conflict of interest policy addresses the relationship between CBHS and the pharmaceutical industry. Its intent is to prevent conflicts of interest and ensure that selection of medications for CBHS clients is based upon objective clinical and scientific evidence. The policy is in alignment with recently revised policies from academic medical centers, self regulated PHARMA guidelines, the Office of the Inspector General, San Francisco Conflict of Interest policies, and NIH guidelines on research.

The policy applies to interactions between CBHS facilities, CBHS staff and all pharmaceutical industries. CBHS facilities include mental health and substance abuse client clinics, programs, urgent care centers, contractors, and individuals who contract with CBHS for the provision of services to CBHS clients. CBHS staff includes all civil service and CBHS-funded program employees including those who are paid, voluntary, or in training.

Pharmaceutical industry representatives (PIRs) are not allowed in any client care facility, including client treatment areas, waiting rooms, clinic entrances, and other protected care areas. The presence of pharmaceutical industry representatives in care areas may infringe upon client confidentiality and creates the appearance that a CBHS facility is receptive to the commercial interests of pharmaceutical companies.

Drug samples, vouchers or drug specific discount cards are prohibited in CBHS facilities. Drug sampling is a marketing tool that encourages physicians and clients to rely on medications that are expensive, but not necessarily more effective than other available drugs. The long term cost of continuing these medications far outweighs any short term savings.

The pharmaceutical industry may not offer or provide any gifts to CBHS staff including meals, medical education (directly or as grants or sponsors), branded office supplies, textbooks, or material items (pens, mugs, pad etc). Evidence shows that gifting can influence prescriber behavior by creating a sense of obligation and reciprocity, resulting in increased prescribing of the company's drugs.

For more information, please refer to the CBHS Policy and Procedure 5.00-03, "Conflict of Interest Policy on Interactions Between CBHS and the Pharmaceutical Industry," or contact CBHS Director of Pharmacy Gloria Lee Wilder, PharmD at 255-3703 or gloria.wilder@sfdph.org

9. Katie A.

Below is the initial plan for developing an implementation plan for Katie A. CYF has established a joint leadership team with HSA. This summer we are continuing our planning process. We have applied to the State to be part of the learning collaborative which will involve working with other counties to develop and innovate Katie A. related services. In September we are planning to have a stakeholders group to present our Readiness Assessment, Service Plan and our intended Deliverables. With the help of our facilitators we will be using the Plan/Do/Study/Act (PDSA) methodology to test small changes. It is our view that by developing a team to innovate we will learn about how best to spread these changes across the system.

AIM:

Design an attachment and trauma focused system with a shared framework that is information driven, integrated, and innovative to support the health, safety, permanency and well-being of children, youth and families that have been involved in or at risk of involvement in Foster Care, Probation, Special Education and are struggling with the complications of behavioral health issues. The goal is to design a system that will serve the Katie A. and non-Katie A. children and families alike.

Key Goals:

- Improve the availability of services
- Improve the effectiveness of services
- Increase family and youth involvement in policy and agency decision making
- Increase the availability and accessibility of interagency training on best practices

Guidance Statement:

1. San Francisco will build on its existing Foster Care Mental Health system and initiate testing of organizational changes that achieve:
 - a. Increased capacity to routinely do timely screening and assessment of all children entering foster care for mental health treatment needs
 - b. Increased coordination of care between CBHS and HSA, as well as with other public and private agencies, families and youth, and other stakeholders
 - c. Increased in-home capacity

DELIVERABLES	DATES
1. Increase the availability of intensive community based services designed to limit placement instability	
2. Increase culturally modified, evidence informed treatments, particularly for youth between ages of birth to 5 years and ages 16-22 years	

3.	Increase family and youth involvement in policy, planning and management decisions for both CBHS and HSA	
4.	Design and utilize a <i>brief version of the CANS</i> tool that will be used for all youth referred to foster care	
5.	Embed a Foster Care Mental Health Assessment Team in HSA	
6.	Child and Family Teams (CFTs) to be expanded for all youth upon entering foster care and will include Clinician from Assessment Team. This Clinician becomes the child's "Central Point of Contact" and remains involved with them throughout their time in Foster Care	
7.	Service providers offering intensive care coordination and intensive in-home services will increase their use of trauma-informed, attachment-based, and resiliency-focused evidence based practices, including those that are adapted to increase culturally competency	
DELIVERABLES		DATES
8.	Develop a Joint Management Team between CBHS and HSA, including its structure, purpose, and processes	
9.	Identify the role of youth and families on the Joint Management Team and offer training, coaching, and mentoring so they can effectively fulfill this role	
10.	Offer trainings on strength-based, collaborative approached for engagement (from the Core Practice Model) to all direct service staff interacting with the youth and families from the following agencies: child welfare, juvenile justice, mental health and special education	
11.	Expand the nature and range of services available to youth in foster care needing intensive mental health services. Services will reflect the following principles: <ul style="list-style-type: none"> a. Services are attachment-focused, resiliency-based and trauma informed b. Treatment is focused on securing meaningful and permanent relationships while helping children and youth heal from trauma, abuse and neglect c. There is at least one constant helper involved in the child or youth and family's healing process d. Intensive treatment is provided flexibly, involving family, caregivers and the child or youth in all aspects of decision-making e. Behavioral treatment is a planned intervention with a clearly defined goals that are collaboratively planned between the youth, family, and their care provider 	
12.	Establish structure and processes for an Implementation and Improvement Team that includes key system of care supervisors, managers, and youth and family partners. This team meets with	

Executive Management Team 1x per month and with a larger stakeholders group (inclusive of juvenile probation, the schools, representatives from provider network, and youth and families) 1x per quarter to review successes and barriers to achievement of SF's Katie. A. Charter	
13. Design a San Francisco Training Manual for providers delivering Intensive Home Based Services (IHBS) and Intensive Case Management (ICC). Also increase collaborative training between HSA and CBHS	
14. Increase Out-of-County Services through contracts with community-based organizations to provide more flexible services in larger geographic area	
15. Attachment and Trauma Training, including a focus on disproportionality	2-3 years
16. Attachment/Trauma Focused Foster and Parenting service models	2-4 years
17. Increase ITFC Slots	2-4 years

Trauma Informed Training:

The trauma informed training initiative is moving forward. Over the past couple of weeks we have had four focus groups to discuss why we are planning on doing a system wide training, some of the curriculum outline and the training delivery mechanism. In coming weeks we will be presenting to Hunters Point Family, TAYSF, and Hope SF. In September the CYF, Adult, Older Adult and Substance Abuse Providers will meet together to discuss and comment on the curriculum and the ideas about how best to deliver the curriculum. In late September we are planning on doing a run-through of the entire curriculum with a select group of non-clinicians to make sure the ideas translate to support and administrative staff. In October we will present to the Change Agents. Between October and January we will refine the curriculum with the intention of rolling it out across community programs in January.

10. Wellness and Recovery – Strengths Assessment

There are times in our work when we will inevitably feel stuck in helping our clients move forward in their efforts to achieve a higher stage of recovery. These impasses in treatment can be frustrating for all parties and often result in an increased sense of hopelessness for our clients and for us as clinicians.

OMI Family Center recently participated in the CIMH Advancing Recovery Practices learning collaborative and began to incorporate into our work a clinical tool which focuses on a client's strengths rather than symptoms and impairments. The Strengths Assessment was developed by Dr. Rick Goscha and Kansas University School of Social Welfare.

At first glance the Strengths Assessment seems quite simple; however, it is truly a dynamic tool. It changes the conversation in the therapeutic hour and as a result a working partnership is created with the shared goal of helping the client move closer to achieving the life of their choosing. When the

conversation shifts in therapy from focusing on deficits to focusing on strengths it is amazing to see the energy and excitement that can be generated from a well-executed Strengths Assessment.

Please take a few moments to review the Strengths Assessment, in the appendix attached at the end of this Director's Report. If you are interested in learning more about how to use this dynamic tool or have any questions, please feel free to contact Gloria Frederico, MFT at Gloria.Frederico@sfdph.org

11. Dr. Tom Bleecker Invited to Expert Panel on Integrated Health Care

The California Institute for Mental Health (CiMH) has invited Dr. Tom Bleecker, a senior Research Psychologist in the Office of Quality Management, to join an Expert Panel of California and National experts to guide and inform changes that will be pursued in a learning collaborative to improve the physical health status of individuals living with mental health, substance use, and physical health conditions. Learning collaborative participants will be introduced to key care coordination processes and client self management approaches to support the physical health of clients, with a particular focus on cardiovascular disease and diabetes risk factors. This coordination will result in a seamless experience of care that is person-centered, cost effective, and results in improved health and wellness. The Expert Panel meeting will be held in Sacramento, California on August 19th and 20th, 2013.

We congratulate Dr. Bleecker on his selection for the expert panel, which follows his insightful presentation of our evaluation of the Primary Behavioral Health Care Integration grant at the California Innovations Summit on May 22, 2013, where he participated in a panel presentation with CBHS Director Jo Robinson and Dr. Deborah Borne. The Summit highlighted San Francisco's model of integrating health care into a behavioral health program at South of Market Mental Health, along with integration models presented by several other California counties.

12. Health Disparities and Hepatitis C

The Impact of life changing break-through in rapid testing and treatment could be huge. The San Francisco Hep C Task Force will host an open meeting with pharmaceutical representatives to explore the strategies to use the innovations to reduce hepatitis related health outcome disparities. For more information: james.stillwell@sfdph (415) 596-5750.

August 8, 2013 at 5:30pm
Quan Yin Healing Arts Center
Suite 405
695 Mission Street
San Francisco, CA 94103

Past issues of the CBHS Monthly Director's Report are available at:
<http://www.sfdph.org/dph/comupg/oservices/mentalhlth/CBHS/CBHSdirRpts.asp>
To receive this Monthly Report via e-mail, please e-mail reanna.albert@sfdph.org

Item 2.0 MENTAL HEALTH BOARD ACKNOWLEDGEMENTS: Cecile O'Connor, Dore Urgent Care, Melissa Nau, MD, San Francisco General Hospital Psychiatric Emergency Services (PES) Director.

The Mental Health Board enjoys highlighting and acknowledging the accomplishments of exceptional people serving Community Behavioral Health Services and our community. Tonight the board acknowledged Dr. Melissa Nau, Medical Director of Psychiatric Emergency Services at San Francisco General Hospital and Cecile O'Connor, Executive Director of Dore Urgent Care Clinic.

Dr. David Elliott Lewis presented Dr. Nau an appreciation plaque for her exceptional work with patients and staff in Psychiatric Emergency Services at San Francisco General Hospital. He also presented another plaque to Ms. O'Connor for her leadership in developing, expanding and sustaining Dore Urgent Care Clinic, a project of Progress Foundation.

ITEM 3.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

3.1 Mental Health Services Act Updates: Mental Health Services Act Annual Update, Marlo Simmons, Director

Marlo Simmons power point document is at the end of the minutes

Dr. David Elliott Lewis welcomed Marlo Simmons, Mental Health Services Act Director who presented the Annual Update of the programs currently funded. State law requires that the Mental Health Board review the Annual Update.

Ms. Simmons said, prior to the Health Commission meeting for approval, the MHSA annual report is posted for a 30 day review.

Dr. Patterson asked if MHSA fund are distributed proportionately among California counties.

Ms. Simmons replied that San Francisco suffered in the original allocations of MHSA funding because we were not permitted to include the number of people who were homeless in our numbers of people with mental illness. We expected \$50 million the first year and received only a \$15 million allocation.

Ms. Virginia Lewis wanted to know why our count of people who were homeless was not included especially since San Francisco has become the dumping ground for the most homeless people with mental illness.

Ms. Simmons said that since quantitative data for the exact numbers of people who are homeless is hard to come by, the numbers were not permitted.

Ms. Robinson explained the other part of funding shortages for San Francisco homelessness is a political issue. During the first realignment in 1991, San Francisco did financially well and other

county councilpersons and city leaders resented us. Since the 1991 realignment, San Francisco has not done well in the MHSA formula.

Ms. Simmons said MHSA funding includes a provision for Full Service Partnerships (FSP) services and program. She introduced Rhea Bailey, who is the programs manager of MHSA, who talked in-depth about the FSP in San Francisco.

Ms. Bailey said the essence of FSP for recovery is "whatever it takes" to support adults with severe mental illness (SMI) and support children with severe emotional disorders (SED). For example, FSP coordinates emergency and permanent housing and works on transitioning clients to lower levels of care. Clients in FSP include people who are homeless, clients with dual diagnoses, elderly, immigrants and disenfranchised people.

Ms. Virginia Lewis asked for the breakdown.

Ms. Bailey said there are 915 clients in total in the program with about 200 children as clients. 57% is for adults.

Dr. David Elliott Lewis asked for the staff to client ratio.

Ms. Bailey The mandated ratio per statute is 1:12 or 1:15 ratios.

Ms. Virginia Lewis asked about referrals and any waitlist.

Ms. Bailey said that referrals can be from hospitals, drug courts, other CBHS programs, Citywide Forensics, and the San Francisco jail system. The waitlist is a work in progress, and Sidney Lam is in charge of that waitlist.

Ms. Robinson added that intensive case management programs are not receiving any financial support from MHSA dollars. So the housing component and FLEX funding are utilized to help clients with recovery.

A challenge for FSP is clients do not want to leave the program. Since FSP provides lots of supportive services that clients do not find somewhere outside of FSP, FSP just offers too much of a safety bubble for people with SMI and SED.

Ms. Virginia Lewis asked what happened to clients who don't want to graduate from FSP.

Ms. Robinson said, in the protective environment of FSP, clients like the services so much that they do not want to leave FSP. Clients are not penalized. The program tries to give clients opportunities to seek meaningful employment so they do not always see themselves as mental health clients forever. Many clients need a job in a protective and nurturing environment.

Ms. Bailey said there is a cultural shift for both clients and staff to increase hope for clients to empower themselves. The shift is very different than the medical model, because a diagnosis is just a small piece of a person and it does not define who the person is!

Ms. Robinson stated that anyone who is a member of San Francisco Healthy Families will need a case manager through the Affordable Care Act (ACA).

Ms. Virginia Lewis wondered how clients stay engaged in FSP because in her private practice she has seen a pattern emerge from isolated clients when they become a no-show for appointments.

Ms. Bailey: The clinical management model has been practiced in SF for years. Now the Affordable Care Act will require the clinical management model in health plans.

Ms. Miller commented that in the MHSA updates, the breakdown of generalized services does not seem to address specificity with respect to client's ethnicity. For example, there appears to be a discrepancy and disproportion in vocational services between people of color and white.

Ms. James asked for statistics for services for older adults/seniors.

Ms. Bailey said older adults/seniors have different needs in services. In the older adults/seniors population, they see more isolation and clinical depression. The programs try to provide linkage to encourage older adults/seniors to engage in their communities.

Ms. James inquired about relapse in older adults.

Ms. Bailey informed the board that older adults who have relapsed do not need to go back to square one of recovery, and staff stay in touch closely with older clients.

Ms. Virginia Lewis: inquired about the data collection process.

Ms. Simmons said it is self reporting and client satisfaction surveys are collected during program review period.

Under SF MHSA service categories, #2 we are required to spend 20% of the MHSA funding on mental health promotion and Prevention and Early Intervention (PEI). For example, we have population-focused mental health promotion. Barbara Garcia's commitment to health disparity is to make investments in the API, African American and Arab communities. We are also focused on transgender client and transgender support services.

Ms. Robison commented that the original supporters of MHSA focused on FSP. But, recently there was bad press and unfair criticism, about how MHSA dollars were being spent in the realm of innovation. For example, the peer support staff wanted a stress reduction program. When the media learned that our yoga cost \$600 for a whole year, the media sensationalized the spending.

Ms. Chien said she is very impressed with the 5% spending on innovation programs under Innovation. She asked for comparative data between the effective usage of dollars in Innovation services and programs versus the traditional services and programs.

Ms. Simmons said their FSP data collection on is very strong showing how clinical services are yielding great results. But prevention data collection is not something we collect. We can see which treatments work effectively. But she is not sure of any comparative data.

Ms. James wanted to know about vocational training program funding for things like uniforms.

Ms. Simmons responded that funding for work uniforms would be in FSP.

3.2 Public comment

No public comment.

ITEM 4.0 ACTION ITEMS

Dr. David Elliott Lewis mentioned that in addition to approval of minutes for the May Board Meeting, the board will be voting on the MHB not having a meeting in August 2013 which was proposed by the Executive Committee.

4.1 Public comment

No public comments.

4.2 PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of June 12, 2013 be approved as submitted.

Unanimously approved

4.3 PROPOSED RESOLUTION: Be it resolved that the Mental Health Board will not meet in the month of August 2013.

Unanimously approved

ITEM 5.0 REPORTS

For discussion

5.1 Report from the Executive Director of the Mental Health Board.

Ms. Brooke announced the following:

1. For those of you who knew Willie B. Kennedy a former Supervisor and recent member of the Southeast Commission passed away and there is a celebration of her life tomorrow and a funeral service on Friday.
2. Wednesday, July 17th is the second forum entitled Managing Stress: Coping Mechanisms for Economic Fatigue at the Holiday Inn Civic Center. This is part of SFMHEF's Path to Mental Wellness Expo in February 2014 which will be at the Oakland Convention Center.
3. Friday July 19th from 10 – 2, Consumer and Family Member conference. Lunch will be served.
4. Thursday August 29th at the Southeast Commission Facility SFMHEF will hold a conference about trauma assessment, diagnosis and treatment planning with Gena Castro Rodriguez.

5.2 Report from the Chair of the Mental Health Board and the Executive Committee.

Dr. David Elliott Lewis attended the Board of Supervisors meeting last Thursday and said the BOS did a great job in honoring the former Supervisor Willie B. Kennedy.

The supervisors did a tribute to Mr. Lou Giraudo who is well-known in San Francisco as a civic leader, a former police commissioner and president and Boudin Bakery co-owner. He was very influential in reviving the troubled \$2.5 billion Cathedral Hill project. Mr. Giraudo is a key negotiator with officials at CPMC Sutter Health for more psychiatric beds in San Francisco for non-privately insured patients.

5.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

None recommended

5.4 Report by members of the Board on their activities on behalf of the Board.

Ms. Miller reported that she attended the CALMHB/C in San Mateo and found it to be very informative.

5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

Dr. Patterson suggested having Supervisors Malia Cohen and London Breed to a board meeting.

Ms. Virginia Lewis asked to have a data person from DPH to talk about health parity – analysis on the Affordable Care Act.

5.6 Public comment.

Ms. Robinson suggested a presentation about vocational rehabilitation.

ITEM 6.0 PUBLIC COMMENT

Ms. Parks thanked the board for helping her when she had an acute psychiatric breakdown.

ADJOURNMENT

Meeting adjourned at 8:34 PM.

Marla Simmons power point document

MENTAL HEALTH SERVICES ACT

FY 13/14
Annual Update



For Mental Health Care



www.YESon63.org

- ☐ Enacted into law in 2005
- ☐ 1% tax on income over \$1 million
- ☐ Designed to transform the mental health system

**“As my life got bigger,
my illness got smaller”**

-TAY Program Participant

MHSA FY 13/14 Annual Update

- ☐ Updates on the implementation of previously approved MHSA Plans
- ☐ Descriptions of services delivered
- ☐ Highlights of outcomes of services provided in fiscal year 2011-12.
- ☐ Reports changes to programs and identify new investments planned for fiscal year 2013-14.

MHSA Integration: Seven Service Categories

- #1: Recovery-Oriented Treatment Services
- #2: Mental Health Promotion & Early Intervention Services
- #3: Peer-to-Peer Support Services
- #4: Vocational Services
- #5: MHSA Housing Program
- #6: Behavioral Health Workforce Development
- #7: Capital Facilities/Information Technology

* Note: Most SF MHSA service categories include programs supported by Innovation (INN) funding.



S.F. MHSA Service Categories

#1: Recovery-Oriented Treatment Services

Services generally provided in traditional mental health system

- ☐ Full Service Partnership (FSP) Programs
- ☐ Behavioral Health Access Center
- ☐ Prevention and Recovery in Early Psychosis Program
- ☐ Trauma Recovery Programs
- ☐ Behavioral Health Integration into Primary Care and Juvenile Justice
- ☐ Dual Diagnosis Residential Treatment

FY 13/14:

- ☐ Expansion/improvement of Full Service Partnerships
- ☐ Enhancing trauma treatment services in southeast



S.F. MHSA Service Categories

#2: Mental Health Promotion and Early Intervention

(PEI) Raise awareness, develop protective factors, reduce stigma, intervene early and increase access

- ☐ Comprehensive Crisis Services
- ☐ School-Based Mental Health Promotion
- ☐ Mental Health Consultation and Capacity Building
- ☐ Population-Focused Mental Health Promotion (NEW)

- | | |
|--|--|
| <ul style="list-style-type: none">▪ Asian and Pacific Islander (API)▪ African American▪ Native American▪ Latino/Mayan | <ul style="list-style-type: none">▪ Arab▪ Homeless Adults▪ Homeless or System Involved TAY▪ LGBTQ |
|--|--|



FY 13/14:

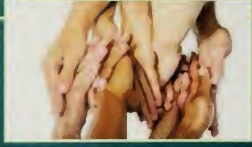
- ☐ Developing holistic wellness services for API and Arab communities
- ☐ Expanding and coordinating services for transgender clients

S.F. MHSA Service Categories

#3: Peer-to-Peer Support Services

Consumers and family members provide wellness, recovery and other support services to their peers.

- ☐ Based in clinic, community, residential and locked settings
 - Office of Self-Help
 - Pathways to Discovery
 - Peer-led Hoarding & Cluttering Program
 - Reducing Stigma in the Southeast (RSSE)
 - Children's System of Care (CSOC)
 - Transgender Support Services



FY 13/14:

- ☐ New clinic-based pilot in partnership with NAMI
- ☐ Peer-to-Peer Services Coordinator – focus on helping develop training, job descriptions, promote professional development, establish clear outcome measures.

S.F. MHSA Service Categories

#4: Vocational Services

Assist consumers and family members in securing and maintaining meaningful employment

- ❑ Vocational IT Program
- ❑ Vocational Co-Op
- ❑ Supported Employment and Cognitive Training

FY 13/14:

- ❑ New re-modeling program – *First Impressions*
- ❑ Vocational Services Coordinator
- ❑ Planning around CYF/TAY vocational services



S.F. MHSA Service Categories

#5: MHSA Housing Program

Continuum of accessible supportive housing to help formerly homeless clients

- ❑ Case management supports to find and maintain housing
- ❑ Short-Term Stabilization Housing (32 Units)
- ❑ Permanent supported housing for adults and older adults
- ❑ Transitional Housing for Transitional Age Youth (TAY)

FY 13/14:

- ❑ Plan strategies for expanding access to housing
- ❑ Interest to buy 3 new units



S.F. MHSA Service Categories

#6: Behavioral Health Workforce Development

Recruit and develop a culturally competent recovery oriented workforce, including consumers and family members

- ☐ Mental Health Career Pathways Program (75 certificate graduates)
 - ☐ H.S. – Community College Certificate – CIIS
 - ☐ Peer Certificate
- ☐ Training and Technical Assistance
 - ☐ 12N – LGBTQI youth sensitivity training for providers
 - ☐ Seeking Safety
 - ☐ Wellness and Recovery
- ☐ Residency and Internship Programs
- ☐ Financial Incentive Programs

☐ FY 13/14:

- ☐ Clinic Intern Coordinator
- ☐ Workforce Assessment focusing on disparities
- ☐ Continue WDET funding



S.F. MHSA Service Categories

#7: Capital Facilities/Information Technology

Acquire, develop, or renovate buildings for MHSA services; upgrades IT systems and improve consumers' access to personal health information.

- ☐ Sunset Mental Health Services JUST OPENED!
- ☐ Integrated Health and Homeless Clinic (IHHC) OPENING SOON!
- ☐ Southeast Health Campus
- ☐ Redwood Center (*project terminated*)
- ☐ Consumer Connect

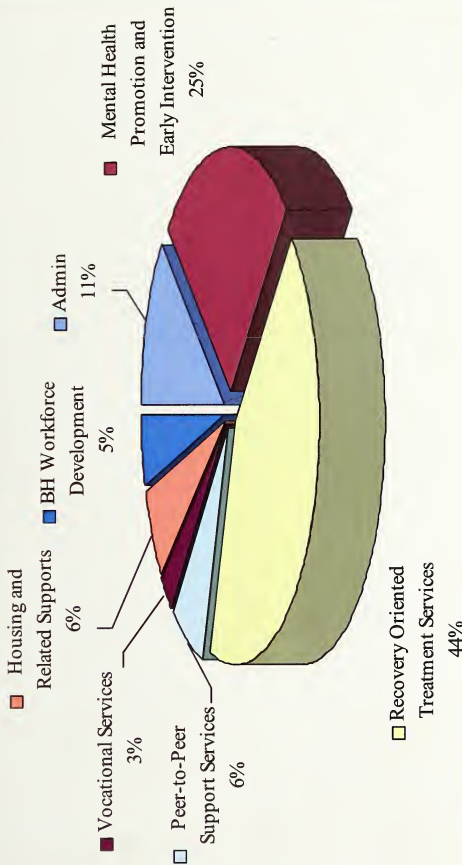


FY 13/14:

- ☐ IT Evaluation and Enhancements

Estimated MHSA FY 11/12 Expenditures by Service Category**

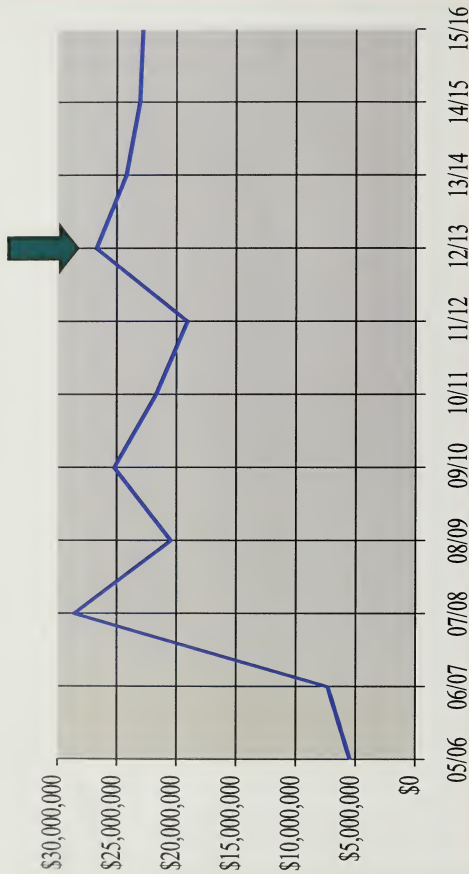
** Does not include expenses for capital projects



Estimated FY 11/12 Expenditures = \$24.5 Million

San Francisco MHSA Revenue by FY

**12/13 and beyond are estimated*



Honoring MHSA Principles

- ❑ **Cultural Competence.** Services should reflect the values, customs, beliefs, and languages of the populations served and eliminate disparities in service access.
- ❑ Expanded access to Spanish and Arab bi-lingual services
- ❑ Began planning to increase access for three API communities with the greatest health disparities
- ❑ Medicinal Drumming Apprenticeship
- ❑ Population Focused Service category helps address specific disparities and access issues for underserved communities
- ❑ Learning Discussions with higher ed partners and leaders in indigenous wellness and community defined evidence

Honoring MHSA Principles

- ❑ **Community Collaboration.** Services should strengthen partnerships with diverse sectors to help create opportunities for employment, housing, and education.
- ❑ Expanded collaboration with violence prevention providers, K-12 Schools, Higher Education, Primary Care, Juvenile Justice, Housing Developers
- ❑ Implemented jointly funded programs with DCYF, HSA, MOH
- ❑ Youth Commission and Human Rights Commission joined forces to develop the 12 N training
- ❑ Fostering partnerships with African American and Samoan church leaders

Honoring MHSA Principles

- ❑ **Client, Consumer, and Family Involvement.** Services should engage clients, consumers, and families in all aspects of the mental health system, including planning, policy development, service delivery and evaluation.
- ❑ Promoted a greater understanding of the value of involving consumers in all aspects of the system
- ❑ Significant client participation on MHSA Advisory Board and other MH planning oversight bodies
- ❑ Programs collecting meaningful client feedback (focus groups, individual interviews, community meetings) that Involvement in program development and evaluation
- ❑ 28 programs funded by MHSA employ consumers

Honoring MHSA Principles

- ❑ **Integrated Service Delivery.** Services should reinforce coordinated agency efforts to create a seamless experience for clients, consumers and families
- ❑ BH staff in 10 Primary Care Clinics and Medical staff in 2 MH clinics
- ❑ Behavioral Health Access Center
- ❑ Promoting linkages with peer navigation – SFGH, Board and Care
- ❑ IT and Capital investments supporting integration
- ❑ Integration of Comprehensive Crisis Services
- ❑ Using peers to engage socially isolated older adults in their homes

Honoring MHSA Principles

- ❑ **Wellness and Recovery.** Services should promote recovery and resiliency by allowing clients and consumers to participate in defining their own goals so they can live fulfilling and productive lives.
- ❑ Training for staff on wellness and recovery practices
- ❑ Learning Collaborative – Expanding PDSA “small tests of change”
- ❑ Annual Award Ceremony
- ❑ Establishment of Wellness Center at Sunset Mental Health Clinic
- ❑ Full Service Partnership Programs help clients maintain housing, integrate back into community, pursue meaningful activities, and gain strategies to cope with stress.
- ❑ Prevention and early intervention programs improve familiarity with behavioral health services and community

supports and increased knowledge of children's emotional

MHSA Program Challenges

- ❑ Turnover
- ❑ Limited capacity for evaluation and data collection
- ❑ Difficult to deepen consumer engagement
- ❑ Limited space to conduct programs
- ❑ Limited funding
- ❑ Limited capacity to support growth
- ❑ Growing and establishing partnerships



Looking Forward

3 Year Integrated Plan (2014 – 2016)

- ☐ A single plan that brings together all MHSA components
- ☐ Guided by State regulations
- ☐ Rooted in MHSA principles and goals, as well as previous community planning priorities
- ☐ Takes into account program outcome data and community specific needs and strengths

Program Monitoring and Evaluation

- ☐ Develop shared outcomes across programs
- ☐ Better integrate MHSA into DPH contracting and program monitoring systems





SAN FRANCISCO MENTAL HEALTH BOARD

Mayor
Gavin Newsom

1380 Howard Street, 2nd Floor
San Francisco, CA 94103
(415) 255-3474 fax: 255-3760
mhb@mentalhealthboardsf.org
www.mentalhealthboardsf.org
www.sfgov.org/mental_health

The **Mental Health Board** meeting scheduled for
August 14, 2013
is

CANCELLED

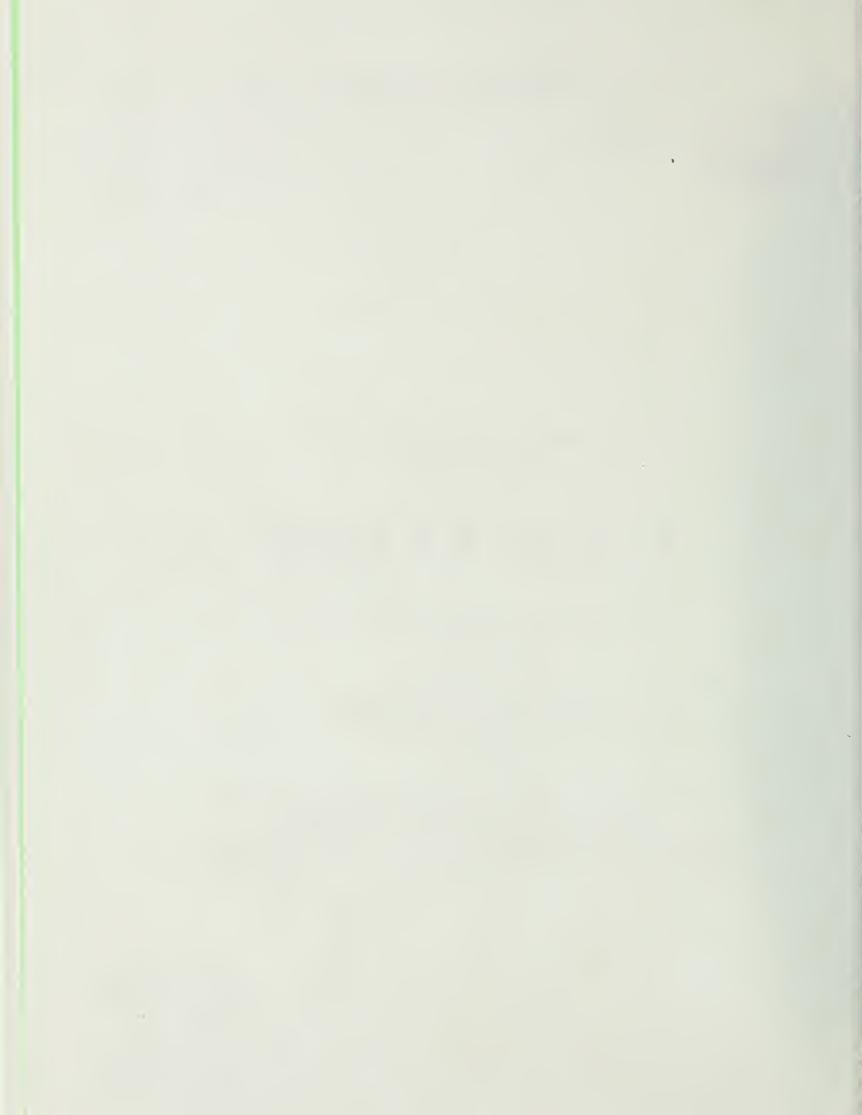
The next meeting of the Board will be Wednesday,
September 11, 2013,
at
City Hall
One Carlton B. Goodlett Place
Room 278
San Francisco, CA

An agenda for the September meeting will be posted online at
www.sfgov.org/mental_health or can be viewed at
the Government Center at the San Francisco Public Library or at
the Clerks Office of the Board of Supervisors in room 244, City Hall.

GOVERNMENT
DOCUMENTS DEPT

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SAN FRANCISCO MENTAL HEALTH BOARD

Mayor Edwin Lee

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www.sfgov.org/mental_health

GOVERNMENT MEETING OF THE MENTAL HEALTH BOARD DOCUMENTS DEPT

SEP - 4 2013

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2nd Floor, Room 278
6:30 PM - 8:30 PM

09-04-13P04:35 RCVD

CALL TO ORDER

Moment of silence to acknowledge victims of September 11, 2001.

ROLL CALL

AGENDA CHANGES

Item 1.0 DIRECTORS REPORT

For discussion.

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public Comment

Item 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

For discussion.

The passage of Proposition 63 (now known as the [Mental Health Services Act](#) or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Updates

2.2 Public Comment

Item 3.0 ACTION ITEMS

For discussion and action.

3.1 Public comment

3.2 PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of July 10, 2013 be approved as submitted.

Item 4.0 PRESENTATION: OVERVIEW OF QUALITY MANAGEMENT AND OUTCOMES MEASUREMENT FOR COMMUNITY BEHAVIORAL HEALTH SERVICES. DEBORAH SHERWOOD, PH.D. DIRECTOR, OFFICE OF QUALITY MANAGEMENT COMMUNITY PROGRAMS SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

4.1 Presentation: Overview of Quality Management and Outcomes Measurement for Community Behavioral Health Services. Deborah Sherwood, Ph.D. Director, Office of Quality Management Community Programs San Francisco Department of Public Health

4.2 Public Comment

Item 5.0 REPORTS

For discussion

5.1 Report from the Executive Director of the Mental Health Board.
Discussion regarding upcoming events, conferences, or activities that may be of interest to board members; Mental Health Board budget issues and update on staff work on board projects.

5.2 Report of the Co-Chairs of the Board and the Executive Committee.
Discussion regarding Chair's meetings with Community Behavioral Health Services staff, meetings with members of the Board of Supervisors and community meetings about mental health or substance abuse.

5.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

5.4 Report by members of the Board on their activities on behalf of the Board.

5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

5.6 Public comment.

5.0 PUBLIC COMMENT

ADJOURNMENT

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2. Meetings are held at City Hall, One Dr. Carlton B. Goodlett Place (between Grove and McAllister), in Room 278. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 71 Haight/Noriega. Also, the J, K, L, M, and N lines underground. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.
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Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: sotf@sfgov.org

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from the Task Force or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: www.sfgov.org/sunshine

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: www.sfgov.org/mental_health. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

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SAN FRANCISCO MENTAL HEALTH BOARD



Edwin Lee
Mayor

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Unadopted Notes

Mental Health Board

Wednesday, September 11, 2013

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

San Francisco, CA

BOARD MEMBERS PRESENT: Ellis Joseph, MBA, Co Chair; David Elliott Lewis, Ph D, Co Chair; Wendy James, Vice Chair; Virginia S. Lewis, MA, LCSW, Secretary; Terry Bohrer, RN, MSW, CLNC; Kara Chien, JD; Terence Patterson, EdD, ABPP; Alphonse Vinh, MS

BOARD MEMBERS ON LEAVE: Melody Daniel, MFT; Lena Miller, MFT

BOARD MEMBERS ABSENT: Marlene Flores, Sgt. Kelly Kruger, Errol Wishom

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Ken Epstein, PhD, LCSW, Director of Children, Youth & Families (CYF) System of Care (CBHS); Deborah Sherwood, Ph.D. Director, Office of Quality Management Community Programs San Francisco Department of Public Health; Wendy Yu; Michael Gause, MHA-SF assistant director; and two members of the public.

CALL TO ORDER

Mr. Joseph called the meeting of the Mental Health Board to order at 6:45 PM.

The board took a moment of silence to acknowledge victims of September 11, 2001.

ROLL CALL

Ms. Brooke called the roll.

AGENDA CHANGES

There were no changes to the agenda.

ITEM 1.0 DIRECTOR'S REPORT

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1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

Dr. Ken Epstein, Director of Children, Youth and Families System of Care gave the director's report on behalf of Jo Robinson.

Dr. Epstein said that CHBS is being trained on implementation of the Affordable Care Act (ACA). He has developed a Trauma Informed Care initiative for CBHS and has been conducting focus groups and presentations to providers. The initiative will be rolled out in January 2014. Next Tuesday there will be a meeting to share this plan with 130 providers. CBHS has also been working on developing a response to the Katie A lawsuit. This lawsuit mandated that all foster youth will be assessed for mental health service qualification. The lawsuit started in Los Angeles's foster care system and found that many children in foster care suffered multiple traumas. San Francisco anticipated the mental health issues in foster care and has been proactive and was already providing mental health screening and services to children and youth in foster care.

1.2 Public Comment

Ms. Dale Milfay said that late onset mental health issues can occur and wanted to know if extra services are provided. She said that some youth with schizophrenia are not diagnosed early enough. The diagnosis is often anxiety and depression and trauma. There are some youth with schizophrenia. Services dollars are scarce to meet the needs of San Francisco youth.

Monthly Director's Report
September 2013

City and County of San Francisco
Department of Public Health
COMMUNITY HEALTH CARE



Mayor Edwin M. Lee

Jo Robinson, MFT
Director
1380 Howard Street, 5th floor
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Monthly Director's Report
September 2013

1. Inspire USA Asks Teens "How Do U ReachOut?" for Suicide Prevention Week

ReachOut.com is launching a campaign for Suicide Prevention Week to raise awareness around self-care and to de-stigmatize help-seeking behavior. "How Do U ReachOut?" consists of Facebook and Twitter profile picture takeovers, an Instagram photo competition, and encouraging e-cards to send to friends. ReachOut's youth will also attend outreach events to raise awareness about services

within each of the newly established ReachOut California chapters. For more information email Liz Crampton at liz@inspire.org.

2. CA State Senate Select Committee on Mental Health Holds Informational Hearing on Suicide Prevention

On Tuesday, September 24th, from 1:00pm-3:00pm, CA State Senator Jim Beall and members of the CA Senate Select Committee on Mental Health will hold an important informational briefing to discuss the future of suicide prevention in California. "Every Life Matters: Implementing Effective Suicide Prevention Strategies in California" will include guest speakers Kevin Hines, who will speak about living mentally well after a failed suicide attempt, along with other national, state and local officials. To stay updated on this hearing, visit the Committee's homepage, or call Diana Traub at (916) 651-4015.

3. The Walk In Our Shoes Campaign is Coming to a School Near You

Stigma and Discrimination Reduction contractor RS&E recently released the Walk In Our Shoes campaign, aimed at 9-13 year olds, which includes a statewide school-based performance tour kicking off in Sacramento on Monday August 26th. View the tour schedule for the next nine weeks at www.walkinourshoes.org. 8/26 – 9/1: Sacramento Region; 9/2 – 9/8: Greater Chico Area; 9/9 – 9/15: Shasta/Redding Area; 9/16 – 9/22: Eureka/Sonoma; 9/23 – 9/29: Bay Area; 9/30 – 10/6: Fresno/Bakersfield; 10/7 – 10/13: Riverside/San Diego; 10/14 – 10/26: Orange County/LA. Contact Kayla Hansen at khansen@rs-e.com to learn more about bringing a performance to your area.

4. Dr. Juan Ibarra to Present at Cultural Competence and Mental Health Northern Region Summit

California Institute of Mental Health's (CIMH) Cultural Competence and Mental Health Northern Region Summit has accepted a presentation titled, "Holistic Wellness – Engaging Cultural and Linguistic Traditions to Improve Community Resiliency" proposed by Juan Ibarra, DrPH, MPH, MSW, of the Office of Quality Management. Dr. Ibarra, an epidemiologist and evaluator of MHSA-funded projects, completed a multi-site evaluation of the Holistic Wellness program, part of Prevention and Early Intervention, in 2012. MHSA funded Holistic Wellness activities at Instituto Familiar de la Raza (IFR), Central City Hospitality House, Bayview YMCA, and Native American Health Center, and included culturally appropriate efforts to outreach into these communities, decrease isolation, increase social connectedness, and connect underserved community members to behavioral health services. Congratulations Dr. Ibarra.

The summit will take place in Modesto, California, October 2-3, 2013 and will focus on "Cultural Competency and Workforce Development: The Bridge to Health Care Reform." Cultural competence skill building workshops and discussions will provide a forum for promoting and advancing cultural competence throughout organizations and systems in order to more effectively meet the needs of individuals and families from diverse communities.

5. State MHSA Audit Critical of State Oversight Agencies; Generates Significant Media Attention

The long anticipated release last week of an audit of the Mental Health Services Act (MHSA) <http://www.bsa.ca.gov/http://www.bsa.ca.gov/> conducted by state auditor Elaine M. Howle was particularly critical of the state entities charged with evaluating the effectiveness of MHSA programs. It said, for example, that “None of the entities charged with evaluating the effectiveness of MHSA programs – Mental Health, the Accountability Commission, or a third entity – have undertaken serious efforts to do so.” The Auditor also audited four counties – Los Angeles, San Bernardino, Santa Clara and Sacramento. While she issued no findings indicating the counties had improperly spent MHSA funds, the auditor did report that “each of the four county departments we reviewed used different and inconsistent approaches in assessing and reporting on their MHSA programs, and the county departments rarely developed specific objectives to assess the effectiveness of the programs.” The audit also found, however, that the state Department of Mental Health “did not provide explicit direction to counties on how to evaluate their programs effectively... When the responsible state entities do not provide guidance to counties for effective program evaluation, the public cannot be sure that MHSA programs are achieving their intended purposes.”

The audit report has generated significant media attention, and resulted in at least one state legislator’s call for annual state audits of each county. Assemblyman Dan Logue (R-Marysville), who is vice chairman of the Assembly Health Committee, says he “will introduce legislation seeking annual audits to show how California counties are spending billions of dollars in voter-approved money for mental health programs, after a state audit found there has been little oversight to ensure the money is going to those who need it most.” According to Logue, “Regular, intensive audits of all 58 counties are needed to ensure they are complying with all aspects of Proposition 63.” Senate Pro Tempore Darrell Steinberg (D-Sacramento) also responded to the audit report with a written statement, which said, in part, “These evaluations have been long overdue. It is vital that investments are held accountable, through objective reviews of their efficacy so that they can be justified, or adapted where improvements are needed.”

CMHDA released its own statement on the day the audit was released. The statement by CMHDA President Jerry Wengerd and Executive Director Patricia Ryan said that “California’s counties have always welcomed the opportunity to demonstrate the value of the community mental health services we provide through the Mental Health Services Act, and are pleased to find that we agree with the findings of the State Auditor today. At the local level, counties have monitored and are proud of the difference our programs are making in individuals’ and families’ lives. Counties have achieved significant reductions in our clients’ levels of homelessness, hospitalization, and incarceration, using Prop. 63 funds. We agree with the Auditor that state oversight agencies must develop an effective and standardized evaluation method so that we can tell these county-by-county stories on a statewide basis. We will continue to participate actively in any Department of Health Care Services and Oversight & Accountability Commission efforts to establish methods for measuring program outcomes, and hope the Auditor’s recommendations in this area will be implemented in a meaningful and cost-effective manner.”

After receiving a request from Senator Steinberg, the MHSAOC has released a six-page MHSA evaluation plan, which has also been circulated with the CMHDA MHSA Committee.

6. CMHDA Sends Letter to HHS Region IX Director Regarding Medicaid “Inmate Exception” Issue

Following the lead of the National Association of Counties (NACo) and the National Association of County Behavioral Health and Developmental Disability Directors (NACBHDD), CMHDA Executive Director Patricia Ryan today sent a letter to Health and Human Services Region IX Director Herb Schultz regarding county Mental Health Plan (MHP) concerns about the effect the so-called Medicaid “inmate exception” rule will have on continuity of care for those individuals who are incarcerated but have not been adjudicated in county jails. The letter requests that CMS “(1) harmonize the definition of “inmate” for Medicaid purposes with the ACA “incarcerated pending disposition” provision, (2) clarify that jail officials may submit Medicaid enrollment applications on behalf of persons in custody, and (3) require that states stop terminating eligibility for persons in custody pending disposition.” Go to: [http://www.cmhda.org/go/Portals/0/CMHDA_Files/Breaking_News/1308_Aug/CMHDA_Inmate_Exception_Letter_Herb_Schultz_\(8-23-13\).pdf](http://www.cmhda.org/go/Portals/0/CMHDA_Files/Breaking_News/1308_Aug/CMHDA_Inmate_Exception_Letter_Herb_Schultz_(8-23-13).pdf)

7. Opioid Overdose Prevention Toolkit

The Opioid Overdose Toolkit educates first responders, physicians, patients, family members, and community members on ways to prevent opioid overdose. The toolkit also explains how to use a drug called naloxone to prevent overdose-related deaths.

Anyone who uses opioids for long-term management of cancer pain or noncancer pain is at risk for overdose, as are those who use heroin. The good news is we now know that the drug naloxone can be used as an antidote to opioid overdose and can prevent opioid-related deaths when naloxone is administered in a timely manner.

Inside the toolkit are five separate booklets, each designed for a specific audience.

- Patients can learn how to minimize the risk of opioid overdose.
- Prescribers can understand the risks of opioid overdose, as well as clinically sound strategies for prescribing opioids, and educating and monitoring patients.
- First responders will find five steps to use in responding to an overdose, including how to use naloxone and provide other life-saving assistance.
- Community members can view facts about opioid overdose that can help local governments, community organizations, and private citizens develop policies and practices to prevent overdoses and deaths.
- Survivors and family members can gain information and support through the information provided in this booklet.

(Attachments 1 – 5)

8. 39th Annual National Suicide Prevention Week

The 39th Annual National Suicide Prevention Week is almost here! Suicide Prevention Week offers an opportunity to inform the public about great strides in addressing this public health issue through prevention.

Thanks to the Mental Health Services Act (Prop. 63), a landmark initiative passed by voters in 2004, California has made a significant investment in programs that prevent mental illness, promote mental health, and connect individuals with help before they reach a crisis point. Guided by the California Strategic Plan on Suicide Prevention - <http://www.mhsoac.ca.gov/docs/Suicide-Prevention-Policy-Plan.pdf> - and funded by counties through the voter-approved initiative, California is implementing comprehensive suicide prevention programs. These programs empower everyone from youth to seniors with the tools, resources, and crisis support needed to prevent suicide.

Suicide Prevention Week puts a focus on the extraordinary efforts to prevent suicide underway in communities across California. New coalitions have been formed and partnerships strengthened to promote the message that suicide is preventable throughout California's diverse communities. Training opportunities and events are ongoing with the goal of raising awareness of suicide prevention tools and resources.

More than 120 Suicide Prevention Week events, sponsored by counties and community partners, have been compiled in a calendar and organized by different types of events. The calendar, which is available at <http://goo.gl/Mmuve7>, demonstrates the breadth and depth of the suicide prevention activities in California – we encourage you to join a local event and spread the word through your networks. Please refer to the attachments of this report to see a few examples of events planned in San Francisco for Suicide Prevention Week and throughout the month of September.

(Attachment 6)

9. Medications and the Elderly: Growing Needs for Coordinated Care

The U.S. Census Bureau projects that the population over the age of 65 in this country will grow from its current 13.7% to nearly 22% by the year 2060. In the year from 2007-2008, nine out of ten older adults were taking at least one prescription drug and 37% were taking five or more.

Medication treatment presents particular challenges in the older patient. As people age, their bodies change in ways that affect how drugs are handled: lean muscle mass and total body water decreases, resulting in a relative increase in total body fat; kidney and liver function can decline; and receptors may become more sensitive to medications. Ultimately, these changes increase the risk of side effects. Moreover, older people tend to have more medical conditions, take more medications and be prone to more memory impairment.

Many providers are familiar with the Beers Criteria, a list of medications that may be considered inappropriate for use in the elderly. This list was updated in 2012 by an interdisciplinary panel with support from the American Geriatrics Society. Here are some of the highlights of the 2012 Beers List as it relates to psychiatric prescribing:

Medication or Class	Concern for the Elderly	Recommendation
---------------------	-------------------------	----------------

Antiparkinson Medications (Cogentin, Artane)	Highly anticholinergic—may cause confusion, constipation, urinary retention, dry mouth. Not recommended for prevention of EPS from antipsychotics	Avoid in elderly
First generation antihistamines (Benadryl, Atarax)	Highly anticholinergic, as above; tolerance develops when used as a sleep aid	Avoid in elderly
Certain tricyclic antidepressants (amitriptyline, imipramine, doxepin)	Highly anticholinergic, as above; , sedating and may cause orthostatic hypotension (dizziness and drop in blood pressure on standing)	Avoid in elderly
Antipsychotics (conventional and atypical)	Increased risk for stroke and mortality in the elderly demented	Avoid in the elderly*
Benzodiazepines (lorazepam, diazepam, temazepam, clonazepam, etc.)	Increased sensitivity, slower metabolism increase risks for these agents, including cognitive impairment, delirium, falls, fractures and motor vehicle accidents.	Avoid for treatment of insomnia,** agitation or delirium
Non-benzodiazepine sleep agents (Ambien, Lunesta, Sonata)	Adverse effects similar to benzodiazepines (see above). Minimal improvement for sleep disorders involving difficulty falling asleep or reduced overall amount of sleep.	Avoid chronic use (>90 days)**
Most antidepressants, antipsychotics and carbamazepine	May cause or worsen a condition that can lower blood sodium levels, which may cause confusion, muscle weakness or seizures	Use with caution (monitor sodium levels closely when starting or increasing doses)

*Although Beers Criteria state to avoid in the elderly regardless of diagnosis, these agents may be considered for treatment of psychotic illnesses in non-demented elderly. **Treatment of insomnia in the elderly should always involve non-pharmacological interventions such as addressing sleep hygiene.

Ideally, the older patient has one provider who has primary oversight of all medications, whether prescribed or over-the-counter, and who can evaluate medication therapy with criteria such as the Beers List in mind. A periodic “brown bag review” of everything the patient is taking can be eye-opening. Open and frequent communication between different providers caring for the same patient is essential, and systems to facilitate this should be promoted. Coordinated systems and support of geriatric care can minimize harm from medications, reduce duplication and other wasteful medication practices, and optimize and simplify regimens to provide the ideal care for our vulnerable elderly patients. With the growth of the older adult population in the coming years, these practices must be a priority.

10. DSM-V

Effective January 1, 2014, San Francisco CBHS will require all of its providers to use DSM-V diagnosis codes in Avatar. DSM-V is the fifth edition of the American Psychiatric Association's (APA) Diagnostic and Statistical Manual of Mental Disorders. The DSM-V codes are already available in Avatar, and can already be used even now, but by January 1, 2014, all CBHS providers are required to use DSM-V diagnosis codes (and no longer DSM-IV). The DSM-V codes are already able to be cross-walked to the ICD-9 codes for Medi-Cal billing purposes.

11. First Impressions - Introduction to the Construction Trades Vocational Training

(Attachment 7)

12. CBHS Outcomes Presentation to Health Commission Community and Public Health Committee

CBHS Quality Management staff gave an update on outcomes and practice improvement activities to the Health Commission Community and Public Health Committee on August 20, 2013 (powerpoint presentation is attached). The first half of the presentation focused on the behavioral needs and strengths identified at intake using the Adult Needs and Strengths Assessment (ANSA), and the percentage of clients who have achieved improvement in at least one domain of need or strength. The second half of the presentation focused on efforts within the Children, Youth, and Families System of Care to better understand and disseminate what practices are effective in our local context.

Dr. Monica Rose, Director of Research and Evaluation for CBHS, presented an overview of the Adult and Older Adult System of Care outcomes. An analysis of initial ANSAs indicated that the top Behavioral Health Needs were Depression (70% of clients), Anxiety (59%) and Adjustment to Trauma (39%). The top Life Domain Functioning Needs were Residential Stability (46%), Social Functioning (45%) and Family Functioning (44%). The highest rated Strength was Involvement in Recovery, whereas the lowest Strength was Community Connection. Over half of clients (57%) had Substance Use identified as an actionable need, and within this group, 21% used alcohol or drugs daily. An analysis of Actionable Needs (those that require action or immediate, intensive action) indicated that there was a positive correlation between the number of actionable needs and the level of care where the client was being served; that is, clients with more needs were being served in higher levels of care, as is appropriate. We also analyzed change over time, from the initial ANSA measurement to the most recent ANSA. Of the 9,297 client episodes of care where there were at least two ANSAs, we found that 68.8% of client episodes showed reliable change in at least one ANSA domain.

The second half of the presentation was lead by Dr. Nathaniel Israel, who reviewed practice improvement methods within the Children, Youth, and Families System of Care using the Child and Adolescent Needs and Strengths Assessment (CANS). CANS data have been provided to programs in the form of pivot charts so that programs can examine the data in a variety of ways (e.g., by demographics, by clinician, etc.). Each program was asked to write their "theory of change," that is, why they believe their services will produce change in the areas of greatest need for their clients. Programs that have succeeded in producing change over time are then asked to identify specific actions they take in response to the needs for which they have successfully achieved improvements.

Dr. Israel is then looking for patterns of successful practice across programs, which can be shared as best practices for other programs who have clients with a similar need profile.

The Health Commission Committee responded favorably to the presentation. CBHS will continue to provide updates to the committee as we learn more from our outcome and practice improvement analyses.

(Attachment 8)

13. Children, Youth and Families

CYF has initiated a process to improve and transform access and client flow within an equity lens. The goal is to ensure that all children, youth and families qualified for specialty mental health services receive the right services in the right place in a timely manner. The CYF providers, county clinics and administration met in July to identify barriers and priorities. A work group has been established that will meet four times to forward a proposal that is inclusive of providers and meets the objective of immediate access and quality services. The plan will involve changes at the provider level, the practice level together with policies that support the desired outcome. The proposal will be presented to the provider group and CBHS administration late in 2013. This initiative is consistent with best practice, the Affordable Care Act but most importantly with the needs of children, youth and families.

14. Tri-Annual Compliance Review of San Francisco CBHS Mental Health Plan

As required by Welfare and Institutions Code, Section 5614, the Department of Health Care Services (DHCS) has informed county Mental Health Plans (MHP) of their respective dates for their tri-annual Program Oversight and Compliance annual review in Fiscal Year (FY) 2013-2014. San Francisco CBHS's tri-annual review is scheduled for April 28, 2014, with San Francisco General Inpatient (psychiatric) taking place earlier on October 7, 2013.

In accordance with oversight authority contained in the California Code of Regulations, Title 9, Chapter 11, Section 1810.380, DHCS reviews the program and fiscal operations of each MHP to verify that medically necessary services are provided in compliance with State and Federal laws and regulations and/or the terms of the contract between DHCS and the MHP. If during the onsite review DHCS determines that an MHP is out of compliance, DHCS will provide a Plan of Correction that includes: description of the finding(s), a description of any corrective action(s) required by DHCS, and the time limits for compliance.

DHCS will also review a random sample of client charts, from across CBHS providers, to determine if medical necessity criteria were met, and recoup Federal Financial Participation (FFP) dollars in accordance with the FY 2013-2014 Reasons for Recoupment, which is available online at: <http://www.dhcs.ca.gov/formsandpubs/Documents/Enclosure%204%20Reasons%20for%20Recoupment%20FY%202013-14.pdf>

The random sample of Non-Hospital Services CBHS charts to be reviewed on April 28, 2014 will be drawn from the most recent 90-day period for which paid claims data are available or from a specified time period as determined by the Department.

CBHS encourages all CBHS providers to strengthen your ongoing quality assurance and utilization review of client medical records. For your reference, the CBHS Mental Health Documentation Manual is available online at: http://www.sfdph.org/dph/files/CBHSdocs/SFDPHDocumentationManual_REVISED_121112.pdf

15. CBHS Peers and Counselors Trained to Implement "Illness, Management and Recovery Groups"

About 50 individuals from across 23 CBHS mental health and substance abuse treatment providers were intensively trained for two days in August 2013 on facilitating "Illness, Management and Recovery" (IMR) groups for clients at their programs. IMR is an evidence-based practice that emphasizes personal goal-setting and actionable strategies toward behavioral health wellness and recovery. The training was conducted by Lucinda Dei Rossi and Debra Brasher of Inspired at Work. The IMR trainees expressed great satisfaction with the training, and enthusiasm is high to apply what they learned.

CBHS will soon regroup all those who were trained for a follow-up discussion on the implementation of the IMR groups at their programs, and the infrastructure that CBHS will put into place to support the implementers, and remove barriers towards successful launching of the IMR groups. Learning for Action, a consulting firm, has also been engaged by CBHS to provide outcomes evaluation support. For information about this IMR Groupwork Project, please contact John Grimes, MFT, Deputy Director, CBHS Adult and Older-Adults Systems-of-Care, at (415) 255-3444, or at john.grimes@sfdph.org.

16. Harm Reduction Coalition

The California Senate and Assembly voted unanimously yesterday for AB 635, carried by Assembly member Ammiano, to decrease overdose fatalities in California by increasing the distribution of an opioid overdose antidote, naloxone. Drug overdoses are now the leading cause of accidental death in the United States, surpassing motor vehicle crash deaths.

Overdose prevention programs distribute the life-saving drug naloxone (also known as Narcan®), which reverses an opioid overdose from drugs like heroin, oxycodone, morphine, or methadone by restoring an overdosing person's breathing and heart rate. The state's longest-running overdose prevention program, the Drug Overdose Prevention and Education Project (DOPE) in San Francisco, a program of the Harm Reduction Coalition, has provided over 3600 take-home naloxone prescriptions since 2003 in collaboration with the San Francisco Department of Public Health, with over 1000 lives saved. In addition, clinicians at SFDPH public health clinics started co-prescribing naloxone with prescription opioids this year to their patients. According to a Centers for Disease Control report, overdose prevention programs distributing naloxone in the US have trained over 50,000 laypersons to revive someone during an overdose to date, resulting in over 10,000 overdose reversals using naloxone. However, many licensed health care practitioners still fear prescribing

take-home opioid antagonists like naloxone to their patients because of potential civil and criminal liability.

This legislation will protect doctors and other licensed health professionals who prescribe and distribute naloxone to those who need it, including at-risk illicit or prescription drug users and potential bystanders to an overdose. It also clarifies that treatment providers and other non-medical personnel are able to distribute the prescription antidote under a doctor's "standing orders". This practice translates into significant cost savings for individuals and taxpayers. Additionally, the bill will encourage health care providers to begin prescribing naloxone to patients on chronic opioid pain medications in order to address the prescription drug overdose epidemic.

Harm Reduction Coalition (HRC), bill co-sponsor with the California Society of Addiction Medicine, applauded the legislature. "In California, overdose prevention programs have operated in a handful of cities and counties, but have had limited reach in terms of addressing the overdose issue statewide because of potential legal concerns," explained HRC California Director, Hilary McQuie. "We trust that Governor Brown will join this bipartisan consensus to protect the programs already operating, remove the obstacles for those that want to start, and clarify that clinicians may employ the 'best practice' of prescribing naloxone to those at greatest risk for having or witnessing an overdose."

The Harm Reduction Coalition (HRC) has been working since 1995 to reduce drug-related harm among individuals and communities by initiating and promoting local, regional, and national harm reduction education, interventions, and community organizing. HRC maintains offices in New York City, NY and Oakland, CA and conducts trainings nationwide. For more information about HRC, visit <http://www.harmreduction.org>.

17. "Remembering" Memorial Lunchtime Concert

You are invited to a "Remembering" Memorial Lunchtime Concert on Friday, September 13th from 12:30 pm - 1:00 pm at Yerba Buena Park Amphitheater. This concert is in memory of friends and family members that have been lost to suicide. Everyone is invited to attend, including those who have not lost anyone to suicide but would like to stand in solidarity and hope. Please pass along this information and flyer to your staff and clients. This concert is free and open to the public. The music and messages of memory and hope are in observation of the National Suicide Prevention Week: September 9-13.

For more information, please contact:
Michelle Thomas
Development & Communications Director
SF Suicide Prevention
Tel: 415/984-1900 ext. 117
Fax: 415/227-0247
P.O. Box 191350, San Francisco, CA 94119-1350
<http://www.sfsuicide.org>

18. Celebrating a Decade of Behavioral Health Court

Behavioral Health Court will celebrate its tenth anniversary this year. In 2003, the San Francisco Superior Court created a program to redirect clients with mental illness out of the jails and into community based mental health treatment. The court started with a modest goal of helping 10-20 people in the jail that were incarcerated for showing signs of untreated mental illness in public.

Ten years later, the court has a capacity of 150 clients and the program is a fully integrated and necessary part of the criminal justice system in San Francisco. Behavioral Health Court has been the subject of numerous research studies and has become a leader in the movement to decriminalize mental illness, reduce violence, and spend precious mental health resources more effectively.

For more information, please contact: (415) 597-8077 or bhcevent@gmail.com.

Past issues of the CBHS Monthly Director's Report are available at:

<http://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSdirRpts.asp>

To receive this Monthly Report via e-mail, please e-mail reanna.albert@sfdph.org

ITEM 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Updates: Mental Health Services Act Annual Update

Dr. Epstein stated that the update is the completion of MHSA statewide audit.

3.2 Public comment

No public comment.

ITEM 3.0 ACTION ITEMS

3.1 Public comment

No public comment.

3.2 PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of July 10, 2013 be approved as submitted.

No vote was taken because there was not quorum.

ITEM 4.0 PRESENTATION: OVERVIEW OF QUALITY MANAGEMENT AND OUTCOMES MEASUREMENT FOR COMMUNITY BEHAVIORAL HEALTH SERVICES. DEBORAH SHERWOOD, PH.D. DIRECTOR, OFFICE OF QUALITY MANAGEMENT COMMUNITY PROGRAMS SAN FRANCISCO DEPARTMENT OF PUBLIC HEALTH

4.1 Presentation: Overview of Quality Management and Outcomes Measurement for Community Behavioral Health Services. Deborah Sherwood, Ph.D. Director, Office of Quality Management Community Programs San Francisco Department of Public Health

Dr. Sherwood's power point is at the end of this document.

Dr. Sherwood said that she has been the Director of Quality Management for the past five years. Prior to this position she did research on children. The Quality Management Department measures how programs meet their outcomes, analyzes the Client Satisfaction Surveys and has the role of Risk Management. They also manage data on the assessment tools, the Child and Adolescent Needs and Strengths (CANS) tool for children and youth, and the Adult Needs and Strengths Assessment (ANSA) for adults. Her department also pilots new ideas with smaller groups. For example, at Mission Mental Health, clients and clinicians are working together on the computer to summarize sessions and goals.

The transition to the Avatar Computer system has been challenging and some of the clinicians are not entering full information, making outcome reports difficult.

We have an Annual Quality Improvement Plan:

1. Improve transitions in care
2. Wellness and recovery
3. Concurrent documentation
4. Improving data quality and reliability
5. Improving productivity
6. Improving medication services

Ms. Virginia Lewis asked if QMO is a self measurement report and how many staff are in the department.

Dr. Sherwood explained that QMO is obtained from clinician outcome measuring reports that come from directly conversational anecdotes that clients report. Monica Rose is the Research Director and she has three staff members. Nate Israel oversees children's research and Tom Bleeker adults. There are three staff with MHSA data and three others on evaluation. Risk Management has two people. The Quality Improvement Coordinator position is currently vacant.

Dr. David Elliot Lewis asked about the milestone of recovery scale (MORS)

Dr. Sherwood explained that clients self identified with collaboration from clinicians as well.

Ms. Virginia Lewis wanted to know about substance abuse if it's self reporting or from toxicology screening.

Dr. Sherwood said that substance use is self reported. She explained that this month director's report provided programs' top issues from depression and anxiety. The report aggregates how effective each program's services are that can be shared with other programs. This peer learning approach has been going on for about six months.

The adult system has been working on identifying best practices for the past two years and the children system has been identifying best practices for about three years.

Programs are also learning from each other to identify best practices.

Some programs have specific outcomes such as Multisystemic Therapy, which involves intensive 24/7 treatment that involves the whole family to prevent recidivism. Also used are harm reduction, Seeking Safety and Triple P Parenting, which is a positive parenting program that is 9 – 12 weeks of intensive training for parents. Research has shown it to be very effective. We also look at re-hospitalization rates.

Terry Bohrer asked about the number of grievances.

Dr. Sherwood said that last year there were 200 and this year only 120.

Dr. David Elliott Lewis asked for average statistics because he has heard requests for services can take months

Dr. Sherwood explained that it is generally 24 – 48 hours before a patient is first seen and time to get services started is about two weeks. The first psychiatric appointment can be a month or two. The time from leaving the hospital to the first outpatient appointment is seven days.

Wellness and recovery does strength based assessments. For example, OMI and Sunset Mental Health and Mission Mental Health are using strength-based assessments. Recovery in mental health means identifying the client's preferred treatment goals, and clinicians work collaboratively with clients to meet the client's self expectation through the use of client's strengths.

Ms. James asked about evaluation for a senior who participates in the recovery model.

Dr. Sherwood shared that recovery might be a day treatment program to prevent seniors from self isolation. Helping seniors overcome their anxiety so seniors can attend day-programs and connect with the outside world. Working from client's strength yield better outcomes for senior clients as well.

Clinicians sometimes get frustrated with Avatar because it can take over 30 minutes to pull up a client's treatment plan. Dual record/notes like a paper copy and an electronic copy is disallowed.

4.2 Public Comment

Mr. John Stetson commented about the 60% reduction in use for patients with substance use, but after clients leave they can't be tracked.

Dr. Sherwood stated that longitudinal analysis of substance abuse is needed.

Mr. John Stetson wondered about the issue on client misreporting their issues

Dr. Sherwood stated that there are no measurements of clients' lack of truthfulness.

Ms. Milfay has 20 years of experience with San Francisco's mental health service system and wanted to know why there isn't more coordination with primary care. Clients with severe mental illness have difficulty accessing acute care beds in San Francisco.

Dr. Sherwood stated that with the Affordable Care Act (ACA), care coordination is important to keep clients engaged with primary care providers. Every client will have a care manager.

Ms. Crystal with Westside asked about major barriers in implementing recovery, because she has seen that many clinicians did not believe in recovery but she feels strength assessment is another tool in their toolkit.

ITEM 5.0 REPORTS

For discussion

5.1 Report from the Executive Director of the Mental Health Board.

Ms. Brooke made the following announcements

- We were recently approved to provide Continuing Education Units to RN's and psychologists attending our Trauma Training Series
- Bayview Foot Print newspaper publication September 6, 2013 is in your packet
- Hyde Street Community Service celebration of its 10th Anniversary on October 3, 2013
- The 6th Annual Family Health Fair at the Southeast Community on October 26th, 2013 from 10 am – 2 pm.

5.2 Report from the Chair of the Mental Health Board and the Executive Committee.

Mr. Joseph reminded the board that the 2013 board retreat will be December 7, 2013 although we do not yet have a venue for it.

5.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

Ms. Chien would like to honor the Lyon Martin Transgender Program.

5.4 Report by members of the Board on their activities on behalf of the Board.

Dr. David Elliott Lewis attended two program reviews: Progress Foundation Dore Urgent Care on Monday, August 26th, 2013 and Residential Care on Friday, September 6th, 2013.

He was very impressed with both programs.

Dr. Patterson attended the recent National Asian Political Summit. He also attended the Affordable Care Act conference.

5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

Dr. David Elliott Lewis suggested Behavioral Health Court, the Peer Response Team and the Mental Health Association Hoarding and Cluttering program.

Ms. Virginia Lewis suggested the Night Ministry which has been operating for 50 years. It is the only social service available from 10:00 PM to 3:00 AM, 24/7.

5.6 Public comment.

Mr. Michael Gause, Deputy Director of MHA-SF talked about SB 82, as proposed by California Senator Steinberg to provide a new source of revenue for mental health programs. Peer crisis respite is an evidence based practice, which is going on in Santa Cruz, to provide a safe space for people in acute crisis. He asked the board for support.

A member of the public stated that she attended the Asian Forum and learned about health disparities in the Asian American community.

ITEM 6.0 PUBLIC COMMENT

Ms. Parks thanked the board for helping her when she had an acute psychiatric breakdown.

ADJOURNMENT

Meeting adjourned at 8:34 PM.

Dr. Deborah Sherwood's Powerpoint

CBHS QUALITY MANAGEMENT OVERVIEW

**SAN FRANCISCO MENTAL HEALTH BOARD
SEPTEMBER 11, 2013**

DEBORAH SHERWOOD, PH.D.
DIRECTOR, OFFICE OF QUALITY MANAGEMENT FOR COMMUNITY
PROGRAMS
PHONE: 415-255-3435
EMAIL: DEBORAH.SHERWOOD@SFDPH.ORG

WHAT DO WE DO?

Measure Client (Adult, Youth & Family) Outcomes
Measure Program Performance
Measure Client Satisfaction
Use Data to Understand What's Working (Organizational
Learning and Practice Improvement)
Use Data to Identify Where We Need to Improve
Coordinate Quality Improvement Activities
Ensure Client and Staff Safety (Risk Management)

CLIENT OUTCOMES MEASUREMENT

Clinical and Functional Outcomes:

- **CANS** (Child and Adolescent Needs and Strengths Assessment)
- **ANSA** (Adult Needs and Strengths Assessment)
 - **Behavioral Health Needs:** Psychosis, Depression, Anxiety, Adjustment to Trauma, Impulse Control, Interpersonal Problems, Substance Use
 - **Life Domain Functioning:** Physical/Medical, Family Functioning, Living Skills, Social Functioning, Residential Stability, Employment
 - **Risks:** Danger to Self, Danger to Others, Self-Injurious Behavior, Grave Disability, Exploitation, Criminal Behavior
 - **Strengths:** Optimism, Community Connection, Spiritual/Religious, Involvement in Recovery/Motivation for Treatment
 - **Other:** Cultural Stress, Medication Adherence

MHSA FULL SERVICE PARTNERSHIP “DCR” OUTCOMES

Clients served in Full Service Partnerships (FSPs) receive intensive, recovery oriented services, often accompanied by transitional or permanent housing

Outcomes are measured quarterly and/or at the time of any significant change in:

- Living Situation
- Education
- Employment
- Legal Issues
- Emergency Interventions (medical and psychiatric)
- Presence of Co-occurring Substance Use Disorder
- For older adults, Assessment of Activities of Daily Living and IADLs

MILESTONES OF RECOVERY SCALE (MORS)

A clinician-rating of a client's level of recovery, completed monthly in all Intensive Case Management Programs, Assertive Community Treatment Programs, and Full Service Partnerships.

The MORS is a single rating on an 8-item continuum of

- Risk
- Engagement in Services
- Skills and Supports

Data are used to identify clients who may be ready to move to a higher level of recovery, or to identify clients who may not be improving with their current array of services.

SUBSTANCE USE OUTCOMES - CALOMS

Outcomes measured annually and/or at discharge from services

Last 30 Days:

- Frequency of primary drug use
- Number of drugs used
- Alcohol use
- Binge drinking
- IV drug use
- Primary care emergency room visits
- Reduction in overnight hospital stays (primary care)
- % of clients not in workforce who are in school or job training
- Number of arrests
- Days incarcerated (jail/prison)
- Days of family conflict
- Days of paid work

EVIDENCE-BASED PRACTICES

Multi-Systemic Therapy (juvenile probation-involved youth
and their families)

Triple-P Parenting Groups

Seeking Safety Groups

Illness Management and Recovery

PROGRAM PERFORMANCE

Performance Objectives

- Rehospitalization rates
- Clinical and Functional Improvement
- Reduction in Substance Use
- Physical Health Screening
- Timeliness of Documentation (assessments and treatment plans)

PROGRAM PERFORMANCE CONT'D

Chart Audits – Quality of Documentation

Timely Access to Care

- Time from request for services to first appointment
- Time from request for services to first psychiatry appointment
- Time from hospital discharge to first outpatient appointment

Client Satisfaction

Child and Family Engagement Survey

QUALITY IMPROVEMENT

Annual Quality Improvement Workplan

Performance Improvement Projects (PIPs)

- Improving Transitions in Care
- Spreading Wellness and Recovery Practices
- Concurrent Documentation
- Improving Data Quality & Reliability
- Improving Productivity
- Improving Medication Services

Using outcome data to understand and share effective practices

Training program staff to conduct rapid tests of change

CLIENT AND STAFF SAFETY (RISK MANAGEMENT)

Investigate Client Grievances

Review and Respond to Incident Reports from Clinics

Conduct Critical Incident Reviews (typically client suicides or homicides)

Identify System Improvement Needs

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SAN FRANCISCO MENTAL HEALTH BOARD

Mayor Edwin Lee

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www.sfgov.org/mental_health

MEETING OF THE MENTAL HEALTH BOARD

Wednesday, October 9, 2013

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

6:30 PM - 8:30 PM

CALL TO ORDER

ROLL CALL

AGENDA CHANGES

Item 1.0 DIRECTORS REPORT

For discussion.

10-03-13 PM 1:52 PM

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1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public Comment

Item 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

For discussion.

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Updates

2.2 Public Comment

Item 3.0 ACTION ITEMS

For discussion and action.

3.1 Public comment

3.2 PROPOSED RESOLUTION: Be it resolved that the notes for the Mental Health Board meeting of September 11, 2013 be approved as submitted.

Item 4.0 PRESENTATION: OVERVIEW OF CBHS PEER-TO-PEER AND VOCATIONAL PROGRAMS, CHARLIE MAYER, LCSW, PEER-TO-PEER AND VOCATIONAL PROGRAMS MANAGER COMMUNITY BEHAVIORAL HEALTH SERVICES

4.1 Presentation: Overview Of CBHS Peer-To-Peer And Vocational Programs, Charlie Mayer, LCSW, Peer-To-Peer And Vocational Programs Manager Community Behavioral Health Services

4.2 Public Comment

Item 5.0 REPORTS

For discussion

5.1 Report from the Executive Director of the Mental Health Board.

Discussion regarding upcoming events, conferences, or activities that may be of interest to board members; Mental Health Board budget issues and update on staff work on board projects.

5.2 Report of the Co-Chairs of the Board and the Executive Committee.

Discussion regarding Chair's meetings with Community Behavioral Health Services staff, meetings with members of the Board of Supervisors and community meetings about mental health or substance abuse.

5.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

5.4 Report by members of the Board on their activities on behalf of the Board.

5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

5.6 Public comment.

6.0 PUBLIC COMMENT

ADJOURNMENT

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SAN FRANCISCO MENTAL HEALTH BOARD

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15-77-15P02:57 3000

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4.1 Presentation: Overview of CBHS Peer-To-Peer And Vocational Programs, Charlie Mayer, LCSW, Peer-To-Peer And Vocational Programs Manager, Community Behavioral Health Services

4.2 Peer Respite in the Bay Area, Michael Gause, Deputy Director Mental Health Association of San Francisco

4.3 Public Comment

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Edwin Lee
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Unadopted Minutes

Mental Health Board
Wednesday, October 9, 2013
City Hall
One Carlton B. Goodlett Place
2nd Floor, Room 278
San Francisco, CA

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BOARD MEMBERS PRESENT: David Elliott Lewis, Ph D, Co Chair; Ellis Joseph, MBA, Co Chair; Wendy James, Vice Chair; Virginia S. Lewis, MA, LCSW, Secretary; Melody Daniel, MFT; Sgt. Kelly Kruger; Kara Chien, JD; Lena Miller, MSW; Andre Moore; Terence Patterson, EdD, ABPP; and Alphonse Vinh, MS.

BOARD MEMBERS ON LEAVE: Terry Bohrer, RN, MSW, CLNC; and Errol Wishom.

BOARD MEMBERS ABSENT: none.

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jim Stillwell, Deputy Director of Community Behavioral Health Services (CBHS); Charlie Mayer, LCSW, Peer-to-Peer and Vocational Programs manager; Michael Gause, Deputy Director Mental Health Association of San Francisco (MHA-SF), Peer Respite in the Bay Area; Michael Gause, MHA-SF; Cynthia Jeanne Lee, MD; Paul Hickman, Family Service Agency of San Francisco; John Stenson, Department of Psychology at San Francisco State University; Bailey Wendzel, Program Coordinator at National Alliance on Mental Illness (NAMI-SF) and seven members of the public.

CALL TO ORDER

Dr. David Elliott Lewis called the meeting of the Mental Health Board to order at 6:35 PM. He introduced Mr. Andre Moore as a new board member, appointed by Supervisor Malia Cohen.

Mr. Moore stated that he was brought up by his grandparents in the City's Alice Griffith Housing Project in Bayview Hunter's Point (BVHP) and still lives in BVHP and is very involved in the community. He works for the Housing Authority and Girls 2000 in San Francisco. He explained that BVHP youth need more education in mental health awareness and outreach services.

ROLL CALL

Ms. Brooke called the roll.

AGENDA CHANGES

There were no changes to the agenda.

ITEM 1.0 DIRECTOR'S REPORT

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

Mr. Stillwell is the Deputy Director of CBHS, and he gave the November director's report on behalf of Ms. Jo Robinson. He reported that, although the electronic health record Avatar system is progressing well, there are still some data errors and further training is needed.

Using evidence-based practices to measure various vocational programs' progress, CBHS staff is tabulating statistics to determine how well vocational services and training are meeting clients' needs. Based on client's self-reporting responses, services and training are effective and have significantly improved clients' recovery.

The Affordable Care Act (ACA or Obama Care) is being instituted as of October 1, 2013. The numbers of workers who are trained in eligibility determination have tripled for Medi-Cal expansion. The extra workers are available to serve lots of people regardless of their insurance status. In January 2014, a bulk of clients will be eligible for Medi-Cal/Medicaid services. The ACA ensures formerly ineligible people are entitled to better health care services.

Mr. Joseph asked about eligibility requirements for the Medi-Cal expansion.

Mr. Stillwell explained that there is very little change in eligibility for currently existing Medi-Cal clients/patients below the 138% Federal Poverty Line. However, for those unqualified, they may need to pay something for services.

The biggest change for San Francisco is not so much about eligibility. The unique geography of San Francisco coupled with the investment from the general funds in healthcare infrastructure that started many years ago has allowed the County and City of San Francisco (CCSF) to be way ahead of the curve. It means San Francisco has been practicing and incorporating mental health and substance abuse services in the primary care setting already. The ROI (return on investment) is more revenues. Many other states and counties appear to be copying San Francisco's health care model, but are facing challenges in implementation.

Ms. Miller commented that she would like to see extra revenues from the expanded Medi-Cal be deployed and distributed proportionally toward community programs that provide recovery and wellness.

Mr. Stillwell said the Board of Supervisors is evaluating the health department's budget impacts.

1.2 Public Comment

Mr. Stenson expressed concern that mental health and substance abuse providers might suffer from burnout because the ACA will, more likely than not, inundate them with new patients/clients.

Dr. Lee commented that the importance of nutrition is often under appreciated. In Europe, there is a correlation that improving nutrition reduced simultaneously both violent behaviors and severity of mental illness symptoms.

Monthly Director's Report **October 2013**

I. Medication Error

Medication error remains the most common type of error that affects patient safety. The National Coordinating Council of Patient Safety defines medication errors as "any preventable event that may cause or lead to inappropriate medication use or patient harm while the medication is in the control of the health care professional, patient, or consumer. It is estimated that 6.5% of hospitalized patients experience an adverse event which is merely a subset of these errors. The magnitude of medication errors in the outpatient setting has been estimated at anywhere from 5-35%. Quantifying the incidence of these errors in the outpatient setting has been difficult as there is no clear monitoring mechanism. In addition, prescribed medications must pass through different processes that can affect how medications will ultimately be taken.

Once medications are prescribed, actions by patients, nurses, caretakers, outside pharmacies, and even third- party payers can introduce further confusion and potential for error. Lack of patient understanding is a very important factor as well. It was reported in 2004 by the Institute of Medicine that nearly half of all American adults have difficulty understanding and acting on health information. Even if there is adequate understanding of the medication regimens, only a small percentage of patients experiencing an adverse event reported the symptoms leading to a physician visit.

Transitions of care such as admission and discharges from the hospital and transfers from one facility to another are an important point where errors can also occur. It is estimated that 46-56% of all medication errors occur at such points. Errors during these transitions consist mainly of incorrect or incomplete transfer of medication information as patient medication histories are generally not integrated among systems.

Measures have been taken to work towards improvements in medication safety. One is the implementation of electronic prescribing which minimizes transcription errors prone to hand written prescriptions. Keeping of accurate records through electronic documentation and access to electronic prescription records also aims to improve timely access to medication information.

Along with electronic prescribing and documentation, it is critical that medication information be reviewed on a frequent basis, particularly when transitions of care occur. The pressure to provide services to a greater number of patients makes providing support and education to patients more challenging. Looking at a team based approach to care by involving nurses and pharmacists in this process has been shown to reduce medication errors during transitions of care.

However, the most powerful tool to ensure medication safety is the empowerment of the patient to become an active participant in their treatment. Asking patients to bring in all medications including herbal and alternative remedies during the medication review process, educating patients on proper indication and administration of medication become critical to ensuring medication safety. As we move into a more team based approach to care with the creation of health homes, using all disciplines with each of their specialties to educate and engage patients in their overall care can lead to improved patient safety and improved overall care.

2. Legislative Hearing Held About Drug Medi-Cal Fraud

The Assembly's Health and its Accountability & Administrative Review Committees held a joint hearing in the Capitol on Sept. 26 about Drug Medi-Cal in response to CNN's allegation of substantial fraud. First on the agenda were comments by Assembly member Richard Pan (D-Sacramento), Chair of the Health Committee, stating that the hearing's intent was to address "widespread fraud" in Drug Medi-Cal and expressing his "outrage" that people are "cheating taxpayers." The first witness was DHCS Director Toby Douglas, who apologized for "serious lapses in state oversight and" said that DHSC is working "to make sure this never happens again." Mr. Douglas and Deputy Director Karen Douglas (no relation) described the actions DHCS is taking to ensure program integrity, including: (a) increasing oversight of state personnel and improved coordination between DHCS, the California Department of Justice (CDOJ), and counties; (b) exploring ways to include counties in the provider certification process; (c) data mining of provider payments to identify red flags; (d) dispatching target teams to visit every outpatient provider; and (e) requiring all medical providers to be enrolled as Medi-Cal providers (beginning January 2014). So far, DHCS has suspended 58 Drug Medi-Cal providers and CDOJ is investigating 64 matters for potential fraud.

A panel of county representatives from Los Angeles, Santa Clara, Contra Costa, and Riverside then described the roles their alcohol and drug departments play in fraud prevention, including audits, reviews, site visits, and client interviews. While Mr. Douglas indicated that counties have not always terminated contracts with providers when they should have, the counties testified stated that they do terminate contracts if warranted. In other instances, these counties said they report providers to DHCS when a state-level investigation is appropriate. The county representatives testified that they would like a role in provider certification. DHCS agreed that the counties should have a role, but wants the state maintains a strong oversight role. Mr. Douglas acknowledged that county mental health plans already successfully manage the delivery of Medi-Cal mental health services contractors, so DHCS is looking for "lessons learned" there. The final witnesses were two contract providers, who described a number of program improvements or expansions they want to enhance the Drug Medi-Cal program. They will be submitting to DHCS suggested changes to enhance accountability, including additional technical assistance and training, requiring programs to have quality improvement systems, establishing medical necessity criteria that can be easily operationalized in clinics, and measuring client perceptions of care.

CMHDA testified during public comment to affirm Mr. Douglas' observation that county mental health departments have substantial experience in, and a successful relationship with the state, ensuring the integrity of the specialty mental health services delivered locally to Medi-Cal beneficiaries. Now that Drug Medi-Cal services have been realigned to counties, CMHDA is

working with the state to identify the tools counties need to assist in the state's efforts to ensure the integrity of the Drug Medi-Cal program. The Assembly Health and Accountability & Administrative Review Committees prepared a background paper.

3. CMHDA Submits Recommendations to the U.S. Senate Finance Committee for Improving the Country's Mental Health System

CMHDA submitted a letter to the U.S. Senate Finance Committee in response to an invitation from Committee Chair Max Baucus and Ranking Member Orrin Hatch for ways to improve the country's mental health and substance use systems. CMHDA made five recommendations:

- Eliminate the Medicaid Institutions for Mental Disease (IMD) exclusion that prohibits facilities with sixteen (16) beds or more from receiving federal reimbursement through Medicaid for people 21-64 years of age.
- Include mental health and substance use providers in the federal Electronic Health Records (EHR) Incentive Program.
- Amend the "deficit-oriented" documentation requirements for Medicare and Medicaid.
- Align Medicaid and Medicare reimbursement methodologies, services, and practices - particularly for dual eligible beneficiaries.
- Fund prevention care for mental health and substance use conditions at the same level as prevention care for other medical conditions.

These will help the country better meet the whole health needs of millions of Americans with untreated mental illness and/or substance use disorders; prevent these diseases in millions more; provide necessary services to those seeking care for, or in recovery from, mental illness or substance use disorders; and lower other societal costs associated with these diseases (e.g., criminal justice, unemployment, emergency medical services, and family financial stability).

4. UC Gears Up for Back to School Season with New Mental Health Trainings and Resources

UC students will return to campuses equipped with better-trained faculty and staff and additional mental health resources this fall, thanks to UC's Student Mental Health Initiative partnership with CalMHSA:

- Five UC campuses launched mental health mobile apps to make it easier for students to access information on what to do if a student is experiencing a mental health crisis or is concerned about a friend. The remaining six campuses will launch apps in the coming months.
- UC Irvine Counseling Center staff were trained as Question, Persuade, Refer (QPR) Suicide Prevention Certified Trainers.
- The UCSF School of Pharmacy trained staff to provide student mental health resources.
- UCLA launched Mental Health First Aid training.
- UC Merced hosted its third annual ASCEND New Student Success Conference that included raising awareness of student mental health.
- UC Berkeley recently launched the "Look for the Signs Campaign," focusing on awareness of depression and how to intervene.

5. October is National Bullying Prevention Month

Resources for educators, mental health staff, parents, caregivers, and community members are available on CCSFSA's Regional K-12 Student Mental Health Initiative Clearinghouse and Website. Contact: Diane Lampe at dlampe@egusd.net or (916) 228-2542.

6. October is Domestic Violence Awareness Month

Throughout the month of October, communities across the country will observe Domestic Violence Awareness Month (DVAM). Activities in honor of victims and survivors of domestic violence will be as varied as the communities and individuals who organize them. Download the facts at <https://www.safehavenonline.org/>

7. Supervised Visitation Grant

SFDPH just received a renewal of our Supervised Visitation Grant by the federal Department of Justice, a program funded for the next 3 years at \$400,000. For information on San Francisco's Supervised Visitation grant, contact Kathleen Minioza at 255-3556 or Alice Gleghorn at 255-3722.

8. Mental Health Services Act (MHSA) Workforce Education & Training (WET) Plan

The Office of Statewide Health Planning and Development (OSHPD) has released the first draft of its new Mental Health Services Act (MHSA) Workforce Education & Training (WET) Plan. Key lights are 1) OSHPD conducted a statewide assessment of workforce, education and training needs of California's public mental health system; 2) there will be a focus on developing a diverse licensed and unlicensed mental health workforce through the following strategies:

- Advance careers that cross new & existing professions; expand capacity of post-secondary education; expand financial incentive programs
- Increase the retention of public mental health workforce in identified high priority areas
- Increase eligibility for federal workforce funding by increasing the number of California communities recognized as designated Mental Health Professional Shortage Areas (MHPSA)

9. Bill Calling for Mental Health Education in Public Schools Signed by Governor - *Focuses on Raising Awareness and Increasing Understanding*

Senate Bill 330, authored by Senator Alex Padilla was signed by Governor Brown on October 3, 2013. The bill would improve the educational framework regarding mental health issues in California public schools. The bill goes into effect on January 1, 2014.

10. Safe Havens: Supervised Visitation and Safe Exchange Grant Program

Community Behavioral Health Services in collaboration with Rally Family Visitation Services, Saint Francis Memorial Hospital, was awarded a three year grant from the Office on Violence Against Women for the *Safe Havens: Supervised Visitation and Safe Exchange Grant Program*. This award provides the opportunity for recipients to develop and strengthen effective responses to violence against women. This cooperative agreement supports supervised visitation and safe exchange

options for families with a history of domestic violence, dating violence, sexual assault, child abuse and stalking. For questions related to this grant, please contact Alice.Gleghorn@sfdph.org

11. Early Childhood Mental Health Consultation Initiative (ECMHCI)

The San Francisco Early Childhood Mental Health Consultation Initiative (ECMHCI) is grounded in the work of mental health professionals who provide support to children, parents and care providers of San Francisco's youngest residents ages 0 – 5 in the following service settings: licensed early care and education centers, licensed family child care homes, homeless and domestic violence shelters, family resource centers, and substance abuse treatment programs. The Initiative is made possible through CBHS' partnerships with First 5 San Francisco, Human Services Agency's Office of Early Care and Education, and the Department of Children, Youth, and Their Families. Services may include program consultation, case consultation, training and support for care providers, referrals for specialized services (e.g., developmental and learning assessments, occupational therapy, help with Individualized Education Plans, psychotherapy), socialization/play groups, 1:1 individualized support to a child in the classroom, direct psychotherapeutic intervention with children and families, crisis intervention, and parent training and support groups. These services are meant to underscore the importance of early intervention and enhance a child's success. In FY 12-13, the ECMHCI served 15,962 people consisting of 8946 children, 5340 parents, and 1676 care providers across 202 sites throughout the city. All program objectives were achieved and demonstrated that care providers and parents had increased understanding of and improved responses to children's emotional, developmental, and behavioral needs.

As lead administrator and coordinator of the ECMHCI, CBHS released an RFP in February of this year in order to continue high quality services. We are pleased to announce that Edgewood, Homeless Children's Network, Infant Parent Program's Daycare Consultants, Instituto Familiar de la Raza, and RAMS' Fu Yau Project are the selected contractors established by the RFP. Under the coordination of Chris Lovoy, CYF Program Manager, these five agencies will continue delivering an array of prevention and treatment oriented services helping thousands of San Francisco's youngest and most vulnerable children.

12. Lynn Dolce, MFT Accepted Position as Director of Foster Care Mental Health

We are pleased to announce that Lynn Dolce, MFT, has accepted the position as Director of Foster Care Mental Health (FCMH) in the Department of Public Health, Community Behavioral Health Services, Children's System of Care. She will begin on Nov 4th. Lynn joins FCMH at a critical time in the collaborative relationship between behavioral health and the foster care system. San Francisco has been a leader in developing a comprehensive system of care for Children, Youth and Families and FCMH has been an innovative program designed to insure that foster care children and youth who need behavioral health services receive it. However, we have a great deal of work to do to improve upon the current outcomes for youth and families in the foster care system.

The Katie A. lawsuit provides a great opportunity to improve care. On March 4th and 5th 2012 a San Francisco Stakeholders group was assembled for a two-day summit, which involved system of care partners, community based organizations and peer families. The group agreed on an AIM for Katie A. redesign. The aim is to design an attachment and trauma focused system with a shared framework that is information driven, integrated, and innovative to support the health, safety, permanency and well-being of children, youth and families who have been involved in or who are at risk of involvement in Foster Care, Probation, Special Education and are struggling with the complications of behavioral health issues. The goal is to design a system that will serve the Katie A. and non-Katie A. children and families alike. We have named this systems change Inter Agency Services Collaborative (IASC).

Lynn Dolce has experience, expertise and is an excellent match to help shepherd us through this process. Since 1990 she has worked as a clinician, a clinical and case management coordinator, clinical supervisor and as a clinical director providing, overseeing and developing services for youth and families faced with severe challenges at an Adolescent Residential Treatment Program, Family Mosaic, The Family Acceptance Project and most recently at UCSF SFGH Child and Adolescent Services. She has served on the clinical faculty for UCSF since 2006 and has distinguished herself as an excellent teacher and trainer. Lynn is a founding member of the Dimensions Clinic in San Francisco and served on the board from 1999-2001. Her clinical skills, supervisory excellence and program savvy will be invaluable.

Please join in welcoming Lynn Dolce.

Past issues of the CBHS Monthly Director's Report are available at:
<http://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSdirRpts.asp>
To receive this Monthly Report via e-mail, please e-mail reanna.albert@sfdph.org

ITEM 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Updates: Mental Health Services Act Annual Update

No MHSA updates.

3.2 Public comment

No public comment.

ITEM 3.0 ACTION ITEMS

3.1 Public comment

No public comments.

3.2 PROPOSED RESOLUTION: Be it resolved that the notes for the Mental Health Board meeting of September 11, 2013 be approved as submitted.

Unanimously approved

3.3 PROPOSED RESOLUTION: Be it resolved that the minutes for the Mental Health Board meeting of July 10, 2013 be approved as submitted.

Unanimously approved

ITEM 4.0 PRESENTATION: OVERVIEW OF CBHS PEER-TO-PEER AND VOCATIONAL PROGRAMS, CHARLIE MAYER, LCSW, PEER-TO-PEER AND VOCATIONAL PROGRAMS MANAGER COMMUNITY BEHAVIORAL HEALTH SERVICES. PEER RESPITE IN THE BAY AREA, MICHAEL GAUSE, DEPUTY DIRECTOR MENTAL HEALTH ASSOCIATION OF SAN FRANCISCO

4.1 Presentation: Overview Of CBHS Peer-To-Peer And Vocational Programs, Charlie Mayer, LCSW, Peer-To-Peer And Vocational Programs Manager Community Behavioral Health Services, Peer Respite In The Bay Area, Michael Gause, Deputy Director Mental Health Association Of San Francisco

Dr. David Elliott Lewis introduced Charles Mayer, manager of the Peer to Peer and Vocational Programs for Community Behavioral Health Services. Mr. Mayer provided the board with an overview of the program. Then Mr. Michael Gause, Deputy Director of the Mental Health Association of San Francisco gave an overview of Peer Respite in the Bay Area.

Overview of CBHS Peer-To-Peer and Vocational Programs, Charlie Mayer, LCSW, Peer-To-Peer and Vocational Programs Manager. His handouts are at the end of the minutes.

Mr. Mayer said that there is a collaboration between CBHS and DOR (the CA Department of Rehabilitation) to provide support for the Vocational Co-Op program. CBHS matches funding from the State California. Vocational Co-Op partners up with Caminar Jobs Plus, Citywide Employment Program, Richmond Area Multi-Services (RAMS) Hire-Ability and Positive Resource Center.

Many clients in the Vocational Co-Op are from either CBHS or referrals. The Co-Op requires clients to be at least 18 years of age with proper work documents, to have an Axis I diagnosis as described in the DSM-5 and to be a resident of San Francisco.

During the early vocational phase, clients receive a lot of assistance based on their strengths. Vocational assessment is a discovery period that takes about two weeks to help clients identify and

address any employment barriers before they are ready for placements. During the initial period of placement, there is an adjustment or "try-out" period of about 4-6 weeks to improve any employment barriers.

The Criminal Justice Specialization offers assistance to clients in need of intensive case management. For example, one of the clients with co-occurring mental illness and substance abuse successfully received a civil service position with the City as a peer counselor. The Vocational Co-Op operates on the strength model rather than the deficit model.

Ms. James asked if the Co-Op program has an age exclusion.

Mr. Mayer said there is no age limitation.

Ms. Virginia Lewis asked how Co-Op clients with intermittent ups-and-downs of mental illness sustain placements.

Mr. Mayer explained that during the first 90 days Co-Op clients receive job coaching, wrap-around intensive case management and all necessary job accommodations and employers who hire Co-Op clients receive a financial subsidy from the State.

Ms. Virginia Lewis asked about partnerships with IT companies

Mr. Mayer said that the Vocational Co-Op is looking for ways to partner with IT firms.

Mr. Stillwell added that IT workers have been demonstrated to be valuable to CBHS, and CBHS is increasingly hiring and retaining Co-Op clients in technical support positions.

Dr. David Elliott Lewis expressed that an employment barrier for recovering clients is going from a zero hour to a 40 hour work week, and wondered if there is any gradual transitional period.

Mr. Mayer explained that as an entry pathway there is usually an option for a transitional employment period. For example, most Co-Op clients start out with less than 20 hours per week. Another viable option is temporary jobs to acclimate themselves into the competitive workforce.

He continued on to say that, besides the Vocational Co-Op, there is the Peer-To-Peer Program to help clients find employment as well. In this program, clients get paid minimum wage for a 24 month peer internship with Pathways and Discovery and Mental Health Association (MHA) Consumer Employment. The peer program starts out in clerical positions though-out CBHS clinics before being promoted into peer counseling positions where they can obtain counseling certificates. The Mental Health Services Act of San Francisco (MHSA-SF) has consumer employment.

Dr. David Elliott Lewis asked how clients become aware and learn about various peer programs.

Mr. Mayer explained that the Peer-To-Peer Program does outreach to recruit new clients throughout different communities, hospitals and jails.

Ms. Virginia Lewis asked about partnerships with non-profit organizations outside of CBHS.

Mr. Stillwell stated most places that provide mental health services are in the CBHS network. In order for non-CBHS peer programs to participate, they must demonstrate their programs work with their clients toward wellness and recovery. They also are asked to document that they are asking clients on a regular basis about vocational interests.

Ms. James wondered how outreach is conducted in the Latino community, since there is so much stigma and discrimination about mental illness.

Mr. Mayer explained that outreach is conducted in all San Francisco communities. The Peer-To-Peer Program has Spanish-speaking staff, and peer-to-peer staff are capable of communicating in seven different languages.

Peer Crisis Respite in the Bay Area, Michael Gause, Deputy Director MHA-SF. His handouts are at the end of the minutes.

Mr. Gause is from MHA-SF and announced that, since November is dedicated to mental health awareness month, there is a free symposium about Peer Crisis Respite and Recovery with Steve Coe, CEO of Community Access in New York City who is the speaker on Friday November 15, 2013.

Senate President pro Tempore Darrell Steinberg authored California SB 82 to allocate about \$4M - \$5M to San Francisco County for treating people with severe mental illness episodes who are deemed a danger to themselves or others. The extra funding would expand mobile crisis and peer respite.

Currently, there are about 20 crisis respite centers in the US. San Francisco currently has no crisis respite. A crisis respite for San Francisco would be an alternative to hospitalization, which can be very expensive. Crisis respites for San Francisco should be operated and staffed by peers and be placed in residential neighborhood to reduce any stigma and discrimination and to provide a safe homelike atmosphere.

There are two peer respite models. The Peer-run model means that at least 51% of board directors are composed of peers with peer staff in charge of daily operation. The Peer-operated model or the hybrid model does not have a 51% of peers on the board, but executive directors and staff are peers. He would like to see the Peer-run model be implemented in San Francisco, because he was very impressed with the Second Story peer-run program in Santa Cruz when he visited it about 10 months ago.

Ms. James asked about the Acute Diversion Units (ADU) and being held accountable by the higher up of management.

Mr. Gause advocated that a peer run model would be more appropriate for San Francisco, because the medical model with clinical staff tends to be very hierarchy and patronizing for patients/clients. In the medical model, clinicians are trained to see patients/clients as a diagnosis rather than seeing them as people, while the peer-run respite would offer better outcomes.

Dr. Patterson mentioned that Second Story in Santa Cruz has a huge operation and wondered how it is working for them.

Mr. Gause stated that Second Story is operated at full capacity with large grants.

Dr. Patterson wondered about court-ordered medication under Kendra's Law in New York and its two respite programs

Mr. Gause said peer respite is voluntary, so it would not be involved with laws such as Kendra's Law in New York or Laura's Law here in California..

Dr. David Elliott Lewis asked about collaborating with the SFPD.

Mr. Gause said he does not know about other counties but believed that if San Francisco could incorporate peer respite in CIT (Crisis Intervention Team) training then it could be another tool for the SFPD to assist citizens in acute crisis.

Sgt. Kruger said any extra acute diversion places for police to help citizens quickly recover from acute mental crisis would be appreciated.

Ms. Virginia Lewis asked if peer crisis respites are anti-psychiatry or anti-psychotic medications.

Mr. Gause explained that peer crisis respites are for people with an acute crisis but not in a full-blown crisis that requires hospitalization. Peer respites are neither anti-psychiatry nor anti psychotic medications.

Sgt. Kruger clarified that peer respite places are non-licensed places, so there is no liability per se.

Mr. Gause said that peer respite is a third option before Psychiatric Emergency Services (PES) and Dore Clinic.

Ms. Virginia Lewis was concerned that the alternative model would be mutually exclusive from the medical model.

Mr. Gause clarified that peer-recovery services are an alternative to the medical model.

Ms. Virginia Lewis asked about financial support.

Mr. Gause hoped to see Kaiser Permanente and San Francisco County provide funding support.

4.3 Public Comment

Mr. Stenson appreciated the presentations and asked about services for veterans and disabled people. He believed more outreach is needed.

Ms. Wendzel is the Program Coordinator for the National Alliance on Mental Illness and she would like to collaborate with the Vocational Co-Op program since NAMI-SF has a peer-services grant.

Dr. Lee, a family doctor, expressed that peer-crisis live-in situations may help peers screen each other for sleep disorders because she believes that it is good to teach peers these skills. She added that peers can teach the importance of maintaining good nutrition and quality sleep to reduce mental crisis.

Mr. Hickman is a Lead Peer Case Aide with Family Service Agency of San Francisco and works with seniors at Curry Senior Center and would like to get seniors into the Vocational Co-Op program.

Public member works at Westside Community Services and would like a set of curriculum on Vocational Co-Op program.

ITEM 5.0 REPORTS

For discussion

5.1 Report from the Executive Director of the Mental Health Board.

Ms. Brooke made the following announcements

- October 16, 2013 is Celebrating a Decade of Behavioral Health Court with a fundraising event. David Elliott Lewis and Ellis Joseph will be attending because the Mental Health Board has been a strong supporter of Behavioral Health Court.
- October 16, 2013 is Twisted Sisters, a presentation about women in the military.
- October 24, 2013 is Trauma, Race, Class, and Gender training
- October 24, 2013 is Art for the House at Hospitality Center.
- October 26, 2013 is the Family Health Fair in the Bayview.
- November 7, 2013 is a Vicarious Trauma and Self-Care training in Oakland and a fundraiser for Oasis for Girls

5.2 Report from the Chair of the Mental Health Board and the Executive Committee.

Dr. David Elliot Lewis reminded the board that the 2013 working retreat is scheduled for Saturday December 7th from 10 – 4 at the San Francisco Police Academy in Diamond Heights.

He also mentioned that on Friday October 11, 2013 MHA-SF is hosting the 2013 Mental Health Services Act (MHSA) Awards. He believes that the MHSA awards ceremony validates and celebrates the recovery achievements of current and former clients in MHSA-funded programs in San Francisco.

5.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

None recommended

5.4 Report by members of the Board on their activities on behalf of the Board.

Dr. David Elliott Lewis will be the MC for the MHSA Award Ceremony on Friday October 11, 2013.

Ms. Miller mentioned that as a result of the District 10 Summit in 2012, DPH is allocating more funding for the District 10 community. She thanked Jo Robinson and Ken Epstein for their support.

Sgt Kruger invited board members to attend the next CIT training from October 21 to 25, 2013 between 8 am to 6 pm.

5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

Sgt Kruger suggested inviting NAMI-SF to do a presentation on supportive services in San Francisco.

Ms. Chien proposed an ACA presentation focusing on the impact on clients

Dr. David Elliott Lewis would like to see a full presentation on CIT from **Sgt. Kruger**.

5.6 Public comment.

Dr. Lee would like to the board to consider a presentation from a sleep medicine doctor who would discuss the relationship between psychiatric disorders and nutrition.

ITEM 6.0 PUBLIC COMMENT

Public member stated that there is so much stigma, discrimination and ignorance surrounding mental illness that the general public does not understand. He felt the MHSA awards ceremony will help people better understand compassionately the challenges that individuals with mental illness face in the recovery journey.

ADJOURNMENT

Meeting adjourned at 8:31 PM.

Documents of tonight presentations

WELCOME TO THE CO-OP



Mental Health Recovery through Vocational Support

From SAMHSA:

(Substance Abuse and Mental Health Services Administration)

Through the **Recovery Support Strategic Initiative**, SAMHSA emphasizes an individual's **meaningful purpose** defined as:

“Meaningful daily activities such as a job, school, volunteerism, family caretaking, or creative endeavors, and the independence, income and resources to participate in society.”

For more info go to: WWW.SAMHSA.GOV

CO-OP OBJECTIVES

Applicable to CBHS Adult Services Programs:

- "Program will make available to clients information regarding vocational opportunities available to them in the community. Programs will have vocational training brochures available in common areas and/or post any community training opportunities on a client bulletin board."
- ▶ Of those clients who remain in an Adult/Older Adult Mental Health Outpatient Program for 365 days or more, at least 25% will be referred to a vocational rehabilitation service.
 - ▶ Of those clients who remain in an Adult/Older Adult Mental Health Outpatient Program for 365 days or more, at least 15% will be enrolled in a vocational rehabilitation service.

Let us Help YOU!!

THE VOCATIONAL CO-

OP Community Behavioral Health Services (CBHS) and the CA Department of Rehabilitation (DOR) have joined forces in partnership with:

- ▶ RAMS Hire-Ability
- ▶ Citywide Employment Programs
- ▶ Caminar Jobs Plus
- ▶ Positive Resource Center

THE CO-OP PHILOSOPHY

All CO-OP partners share
the philosophy of:

- ▶ providing exceptional
vocational services and
- ▶ consumer advocacy



- ▶ EMPLOYMENT
- ▶ INDEPENDENT LIVING
- ▶ EQUALITY FOR INDIVIDUALS
WITH DISABILITIES

MORE ABOUT THE CO- OP

- ▶ Utilizes a Team Approach
- ▶ Instills Hope
- ▶ Uses a Harm Reduction Approach
- ▶ Focuses on a Client's Strengths
- ▶ Believes in Client-Driven Services
- ▶ Takes a Holistic Approach
- ▶ Encourages Peer Support
- ▶ Respects Cultural Diversity
- ▶ Involves the Family and Community

We Meet the Clients Where They Are!

VOCATIONAL CO-OP SERVICES

- ▶ Pre-Vocational Services
 - ▶ Vocational Assessment
 - ▶ Situational Assessment
 - ▶ Work Adjustment
- ▶ Vocational Skills Training
 - ▶ Competitive Community Job Placement
- ▶ Job Coaching
- ▶ Criminal Justice Specialization

PRE-VOCATIONAL

OB S E R V I C E S

are participants for competitive employment and assist them in developing work readiness skills in a structured group setting.

- ▶ Orientation
- ▶ Readiness for Change
- ▶ Stress Management
- ▶ Self Discovery
- ▶ Getting Ready for Work
- ▶ Time Management
- ▶ Learning Styles
- ▶ Communication Skills
- ▶ Know Your Rights
- ▶ Benefits Management

VOCATIONAL

ASSESSMENT

OBJECTIVE: to determine the comprehensive interviewing, clients' interests and goals, vocational history, vocational skill sets, potential assistive technology requirements, skills, and barriers.

suc·cess

(sək-sēs') *n.*

1. The achievement
of something
desired.

SITUATIONAL

ASSESSMENT
OBJECTIVE: to identify barriers to employment, work readiness, skills and strengths using observation of actual or simulated work situations

Consumers perform work in the following settings:

- ▶ Assembly work
- ▶ Career Exploration
- ▶ Janitorial
- ▶ Café
- ▶ Clerical (*under development*)

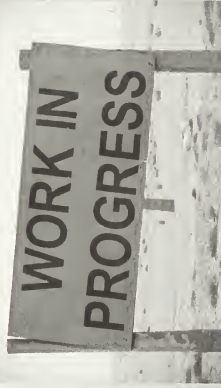


WORK ADJUSTMENT

OBJECTIVE: to use real paid work placement to address barriers to employment and to train consumers in the demands of a job such as work tolerance and behaviors appropriate for work.

Consumers perform work in the following settings:

- ▶ Assembly work
- ▶ Career Exploration
- ▶ Janitorial
- ▶ Café
- ▶ Clerical (*under development*)



VOCATIONAL SKILLS

OBJECTIVE: to provide training for consumers who are interested in receiving a specialized certificate.

Janitorial

- ▶ Green Clean Certification available by examination.
- ▶ Classroom training and hands-on janitorial fieldwork training.

Clerical

- ▶ Training in customer service, data entry, internet, e-mail, Microsoft Excel, Microsoft Word, PowerPoint, office machines and front desk management.

IT HelpDesk

- ▶ Paid on the job training providing front-end computer user support and customer service.

IT DeskTop

- ▶ Paid on the job training in IT desktop and technical support, hardware break/fix and software support.
- ▶ Preparation for the A+ certification test.

COMPETITIVE COMMUNITY JOB PLACEMENT SERVICES

OBJECTIVE: to assist consumers with job preparation and placement

- ▶ resume building
- ▶ job placement

▶ job retention
Placements are made in volunteer positions, stipend employment and competitive employment opportunities and are based on clients' interests, strengths, resources, priorities and abilities. Peer support is strongly encouraged for obtaining and maintaining employment.

CURRENT COMMUNITY PARTNERS:

Safeway	Target
Ross	SFUSD
La Boulange	Whole Foods
Local Small Businesses	The Gap
Non-profits	Manpower Temp Services
	CBHS Peer Program

JOB COACHING

OBJECTIVE: to provide consumers both on- and off-the-job, one-on-one, employment-related assistance and support in activities needed to promote job adjustment and retention.

suc·cess

(sək-sēs') *n.*

1. The achievement
of something
desired.

CRIMINAL JUSTICE SPECIALIZATION

OBJECTIVE: to provide services that are integrated in an intensive case management program which—

- ▶ specialize in chronic and persistent mental illness and co-occurring substance abuse issues.
- ▶ assist high users of hospitals and criminal justice institutions

DISTINGUISHING FACTORS

PARTNER PROGRAMS

ALL PROGRAMS:

- ▶ Vocational Assessment
- ▶ Competitive Community Job Placement Services
- ▶ Job Coaching (if applicable)

RAMS:

- ▶ Pre-Vocational Services and Support
- ▶ Janitorial, IT Helpdesk and Desktop Training

CAMINAR:

- ▶ Skills Assessment
- ▶ Employment Services

CITYWIDE:

- ▶ Wrap-around Intensive Case Management Services
- ▶ Criminal History Specialization

POSITIVE RESOURCE CENTER:

- ▶ Clerical Training

SERVICE LANGUAGES

RAMS

- ▶ English
- ▶ Cantonese
- ▶ Mandarin
- ▶ Tagalog

Citywide

- ▶ English
- ▶ Spanish
- ▶ Russian
- ▶ French

PRC

- ▶ English

Caminar

- ▶ Spanish
- ▶ English

ELIGIBILITY

- ✓ 18 years old and up
- ✓ Have a mental health diagnosis
- ✓ Have documentation to work in the U.S.
- ✓ Be a San Francisco resident

WHAT'S NEXT AFTER THE REFERRAL?

- ▶ CBHS staff completes the referral process.
- ▶ The program contacts the client and schedules an orientation.
- ▶ The program requests ANSA Assessment and medication sheet.
- ▶ Intake at selected CO-OP program
- ▶ Access to vocational services begin
- ▶ Ongoing collaboration between mental health provider and vocational program

THE MH CLINICIAN'S ROLE ONCE A CLIENT IS PLACED?

THE CLINICIAN CAN:

- ▶ assist in problem-solving and helping clients to address difficulties in their work environment.
- ▶ let the vocational program know how the client is doing and how the program can best help the client's treatment process.
- ▶ engage in ongoing contact and case conferences with CO-OP providers to help the client reach his/her vocational goals ultimately reducing mental health symptoms.

COLLABORATION IS THE KEY TO SUCCESS!

SUCCESS STORIES

Moving, Moving, Moving!

The Vocational CO-OP
serves approximately 860
clients per year

Since 2009, over 350
clients have been placed in
the competitive workforce

LOCATIONS/CONTACT US

RAMS Hire-Ability

1234 Indiana Street

SF, CA 94107

Nancy Gobaleza

Intake Coordinator

415-282-9675 x 207

www.hire-ability.org

Caminar Jobs Plus

Temporary location at:

301 Howard St

SF, CA 94105

Kristy Adams

Intake Coordinator

415-632-8854

www.caminar.org

Citywide Employment Programs

982 Mission Street

SF, CA 94103

Gregory Jarasitis

Employment Programs Manager

415-597-8057

www.cw-cf.org

Positive Resource Center

785 Market Street, 10th Floor

SF, CA 94103

Joe Ramirez-Forcier

Employment Services Managing Director

415-972-0831

www.postiveresource.org

LOCATIONS/CONTACT US

CBHS Vocational Services

1380 Howard Street, 5th floor

SF, CA 94103

Charlie Mayer

Vocational Programs Manager

415-255-3417

charles.mayer@sfdph.org

Department of Rehabilitation

301 Howard Street , Suite 700

San Francisco, CA 94105

415-904-7100

www.dor.ca.gov

LET'S TALK ABOUT THE CO- OP

- ▶ Do any of your clients want to work or want to make a job change?
- ▶ What difficulties have your clients had looking for work?
- ▶ What barriers do your clients face during their job search?
- ▶ What vocational training programs would be of interest for your clients?

Evaluating Peer-Operated Crisis Care Alternatives

Laysha Ostrow, M.P.P.
Johns Hopkins Bloomberg School of Public Health
Presentation to Columbia University/Nathan Kline Institute, September 2012

Outline

- ▶ Review of the model of peer-run and -operated crisis respite
- ▶ Characteristics of existing respite
- ▶ Peer-run respite in the continuum of care and community
- ▶ Sustainability: Shifting funding from state/county funds to Medicaid reimbursement
- ▶ Research and Evaluation: Results of survey of existing respite
- ▶ Recommendations on evaluation

Background

- ▶ Hospitalization for people experiencing a psychiatric crisis is often traumatic, costly, and does not provide recovery-oriented services.
- ▶ Alternatives to hospitalization are needed.
- ▶ Mental health consumer/survivors have created alternatives to hospitalization, called peer-run crisis respites.
- ▶ There are 13 existing respites

What are Peer-Run Crisis Respite?

- ▶ Peer-run respites are crisis alternatives with the intended outcome of diverting hospitalization
- ▶ They are staffed and operated by peers who have professional training in providing crisis support to build mutual, trusting relationships
- ▶ Peer-run respites are usually located in a house in a residential neighborhood. They provide a safe, homelike environment for people to overcome crisis

Models of Peer-Run Respites

- ▶ Peer-run indicates that the board of directors is at least 51% peers
 - ▶ peers staff, operate, and oversee the respite at all levels
- ▶ Peer-operated (hybrid) indicates that although the board is not a majority peers, the director and staff are peers
 - ▶ Attached to a traditional provider

Peer-Operated Respites as an Adaptation

- ▶ “We call peer-run “pure” and peer-operated “hybrid”
 - ▶ There is implicit judgment in this language, but it’s most important that the services and the people providing them reflect the values
- ▶ Traditional providers are trained in hierarchical power dynamics in treatment – this is what they know (whether they are aware or not)
 - ▶ Psychiatrists on staff or consultation for peer-operated respites should be selected carefully and offered training in peer support modalities and shared/supported decision-making

Existing Respites

Ostrow, 2012

Respite Name	State	Guests	LOS	Model
Stepping Stone Peer Support & Crisis Respite Center	NH	2	1-7	Peer-run
Sweetser Peer Support & Learning & Recovery Center	ME	3	3-5	Peer-operated
Georgia Peer Support and Wellness Center	GA	3	Up to 7	Peer-run
Peer Support, Wellness, and Respite Center of Bartow County	GA	3	Up to 7	Peer-run
Peer Support, Wellness, and Respite Center of White County	GA	3	Up to 7	Peer-run
Rose House Hospital Diversion Program by PEOPLE Inc. (Milton)	NY	4	1-5	Peer-run
Rose House Hospital Diversion Program by PEOPLE Inc. (Putnam)	NY	3	1-5	Peer-run
Voices of the Heart, Inc.	NY	2	1-3	Peer-run
Foundations: A Place for Education and Recovery	OH	3	3-5	Peer-run
Keya House	NE	4	Up to 5	Peer-run
2 nd Story Santa Cruz County	CA	8	8	Peer-operated
Alyssum	VT	2	14 +/-	Peer-run

Ostrow, 2012

Respite Name	State	Funders	Budget
Stepping Stone Peer Support & Crisis Respite Center	NH	NH State General Funds and Federal Block Grant	\$353,180
Sweetser Peer Support & Learning & Recovery Center	ME	Sweetser and their Endowment of Mental Health and United Way	\$308,500
Georgia Peer Support and Wellness Center	GA	Georgia's Department of Behavioral Health and Developmental Disabilities (GBHDD)	\$354,000
Peer Support, Wellness, and Respite Center of Bartow County	GA	GBHDD	\$325,000
Peer Support, Wellness, and Respite Center of White County	GA	GBHDD	\$325,000
Rose House Hospital Diversion Program by PEOPLE Inc. (Milton)	NY	Orange County	\$270,00
Rose House Hospital Diversion Program by PEOPLE Inc. (Putnam)	NY	Putnam County	\$290,000
Voices of the Heart, Inc.	NY	NYS Office of Mental Hygiene, Warren and Washington County and Private supporters	\$150,000
Foundations: A Place for Education and Recovery	OH	Stark County Recovery Services Board (Canton)	\$160,000
Keya House	NE	State Division of Behavioral Health	\$266,000
2 nd Story Santa Cruz County	CA	SAMHSA Mental Health Transformation Grant Ostrow, 2012	\$478,650
Alyssum	VT	State of Vermont	\$369,000

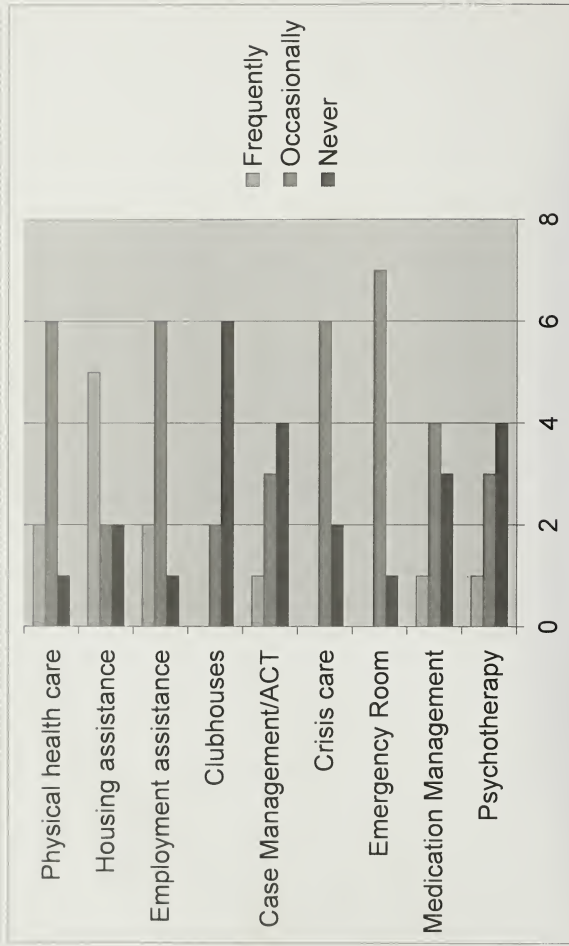
In the continuum of care

Ostrow, 2012

Alternatives or Adjuncts?

- ▶ 8 felt that their organization's activities were an *alternative* to hospitals and ERs
- ▶ 2 saw their activities as a service that can be used *in addition* to hospitals and ERs.
- ▶ When comparing peer run respites and inpatient and ER...
 - ▶ 2 thought people should *only* use peer run respites
 - ▶ 7 thought people should *mostly* use peer-run respites, but sometimes use hospitals and ERs
 - ▶ 1 thought people should use both *equally*
 - ▶ None thought people should mostly use hospitals and ERs, and sometimes use peer-run respites

Referrals to other providers



Referrals from providers

- ▶ All respites reported that other providers either occasionally or frequently refer people to their services. None reported that providers never refer to them.

Sustainability

Ostrow, 2012

Reimbursement

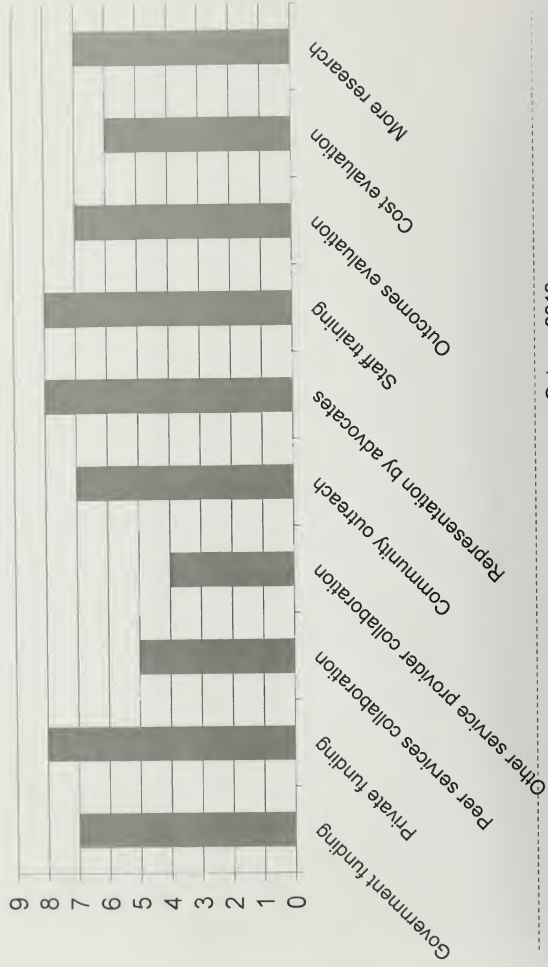
- ▶ Peer-run respites are not Medicaid reimbursable at this time, but future funding could eventually come from a combination of state revenues, block grant dollars, Medicaid, and Medicare.
- ▶ Respite directors were asked whether they would be willing to accept Medicaid reimbursement
 - ▶ 6 respondents were willing to become Medicaid providers, but had concerns
 - ▶ 4 were unwilling to become Medicaid providers

Concerns about Medicaid reimbursement	Responses
Do not want to have to justify medical necessity	9
Afraid cannot remain advocates if part of an insurance company network	7
Detract from our mission of focusing on recovery, and make us focus on money	5
Not enough financial staff to manage the billing	2
Do not want to participate in Medicaid's requirements for quality and performance measurement	2
Do not have computer systems secure enough	1
Do not want to be audited by an insurance company	1
Do not want to go through the application process	0
Do not have enough administrative staff to handle the paperwork	0

Other concerns

- ▶ Medicaid required clinical/medical supervision
- ▶ Medical model language is “demeaning and inaccurate”
- ▶ Rates may not be acceptable for funding needs
- ▶ There are issues because of the values and principles of the consumer/survivor/ex-patient/peer movement
- ▶ Taking Medicaid brought up issues around forced and coercive treatment

What programs need to be effective



Research and Evaluation

Ostrow, 2012

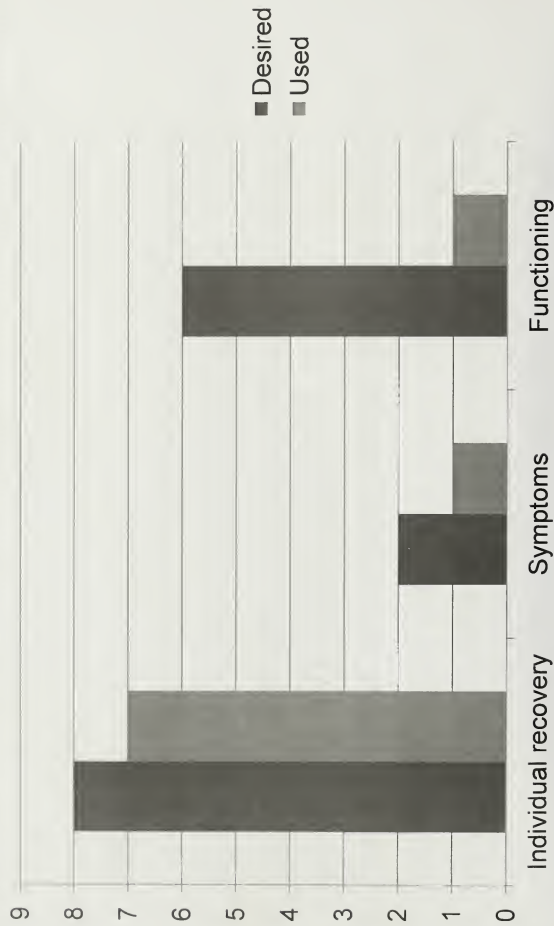
Research & Evaluation

- ▶ Evaluating peer-run respites is an important next step in their development and implementation
- ▶ They must be evaluated for cost, outcomes, and cost-effectiveness if they are to succeed
- ▶ To date, there has not been large scale, multi-site, quantitative evaluation of organizational processes, utilization, outcomes, or costs
- ▶ The intended outcomes are not the same as traditional services
 - ▶ Transforming systems means transforming how we conceptualize effectiveness

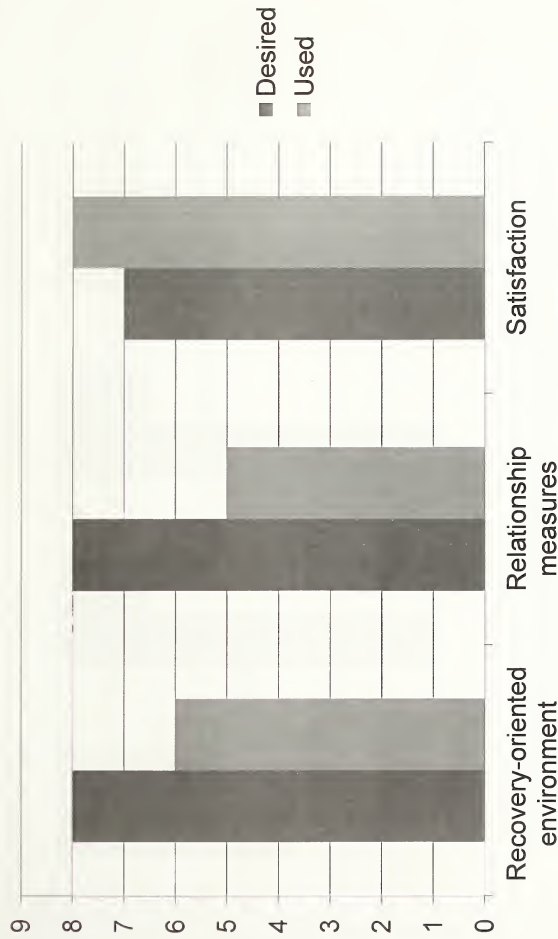
Existing respite's evaluation

- ▶ All programs have been evaluated at least once, except one that has only been open for two months.
- ▶ One had been evaluated twice, and six had been evaluated 3 or more times.
- ▶ Only one respite had participated in an evaluation where there was a comparison group.
- ▶ All of the directors wanted their program to be evaluated in the future.

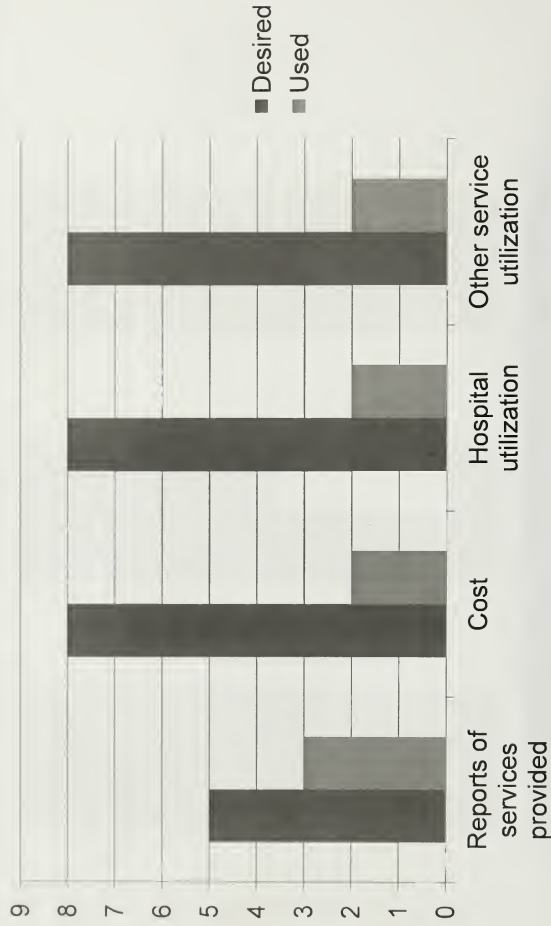
Individual outcome measures



Program context measures



System level measures



- ▶ The greatest disparity was in system level measures
 - ▶ These are the measures that policy-makers are most interested in
 - ▶ Success in these kinds of measures will lead to greater sustainability

Recommendations on Evaluation of Existing Respites & Parachute

Ostrow, 2012

Research Teams

- ▶ Principal Investigators: “Psych survivors” or “Allies”?
 - ▶ “Bias” and insight are two sides of the same coin
- ▶ Interviewers should be peers
 - ▶ As with any interviewers, training is essential, but if interviewers are trained in peer support previously, there could be more issues with interviewing technique
- ▶ Consumer input on measurement selection, data analysis, and interpretation/dissemination of results
- ▶ Recommend having an economist on research team

Research Design and Measurement

- ▶ Recall concerns of “ethics” of randomization in COSP study
 - ▶ “Hospitals are not an EBP” – but neither are respite
- ▶ Cost-effectiveness will be essential
 - ▶ Given equal outcomes, the lower cost alternative is the better choice
- ▶ Re-hospitalization rates and other service use
 - ▶ Hospitals are driver of health care costs; medications are also driving costs
 - ▶ “Coming off drugs” movement vs. unmet treatment need debate
 - ▶ Not our place as evaluators to make judgment about medication use as good or bad – but important to measure and correlate with reduced/increased service use and other outcomes
 - ▶ Need cooperation of local systems in tracking data – advise having your own data person who can access these data

Research Design and Measurement, ct'd

- ▶ The creation of alternatives to hospitals is because of survivors' experience with force/coercion/oppression of institutions
 - ▶ To show that respites are a better alternative, force and coercion are essential to measure
 - ▶ Possible validated measure is the McArthur Coercion Scale
 - Would have to be adapted to replace "hospital" with "respite" to make comparisons
- ▶ Satisfaction measures are easy to administer, but have become a folly of mental health services research
 - ▶ Satisfaction research is known to be biased positively
- ▶ Recovery measures not relevant
 - ▶ The goal of crisis care is addressing immediate issues. Recovery is a life-long process and I would not expect valid changes in scores; especially issue of regression to the mean and crisis being "rock bottom"

Discussion & Questions

Ostrow, 2012

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This research supported by NIMH grant T32MH019545

Community Access, Inc. – Crisis Residence Program Description

Excerpts from New York State Office of Mental Health

EZ PAR application #636, June 2013

Overview

The crisis residence program planned for this application will be a maximum 12 bed facility with a length of stay not to exceed 30 days. Referrals are expected to come from inpatient psychiatric hospitals, clinics, health plans, primary care physicians, therapists, self-referrals, family members, and the behavioral health provider community.

The operating guidelines for this license is are included in Part 589 and 589-1, Codes, Rules and Regulations of the State of New York for the Operation of a Crisis Residence.

Based on discussions with interested parties, the initial crisis residence will be located in Brooklyn, NY. Community Access anticipates opening additional residences, and creating ancillary hospital diversions services, in other areas of New York City as demand dictates.

Engagement and Assessment Processes

Guests arriving at the crisis respite center will be greeted by a peer staff member for an initial meeting that reviews the purpose of the respite center and the rights and responsibilities of guests during their stay. These rights include:

- The right to be treated with dignity and respect.
- The right to privacy and confidentiality.
- The right to access his/her personal medical record, including recovery plan, notes, assessments.
- The right to be fully informed about services, medications and treatment options.
- The right to refuse services and/or medications.
- The right to file a grievance.
- The right to participate in recovery and discharge planning in a full and meaningful way.

Staff will be trained to engage in ongoing and collaborative assessments with guests as indicated by individual circumstances. Within 24 hours of admission, an initial assessment will be conducted to identify the unique strengths, resources, needs, barriers and priorities of each individual. Areas that will be explored in this assessment will include health and wellness, social connections, physical environment and personal growth. Additional screenings may include trauma, physical health, substance use and work. Some assessments may be skipped until a later time, depending on individual circumstances and preferences articulated by the guest.

Every guest will be evaluated regarding basic physical health needs. The purpose of this assessment is to detect any underlying physical health issues that a) need immediate attention to prevent a medical emergency, and b) should be taken into account when developing the recovery plan.

Because neuroleptic medications play such a major role in the mainstream treatment of mental illness, and because of the profound side effects of these medications, the health assessment will include a detailed review of medication history and a preliminary plan for medication optimization.

Recovery Planning

The initial assessment will be the basis for the individual recovery plan, ideally established within 24-48 hours of admission. The plan will be reviewed daily and updated as needed. The recovery plan will include many principles found in Mary Ellen Copeland's Wellness Recovery Action Plan and related concepts. The guest will be a partner in the formulation of the plan. Guest choice and preference will guide the process. Each plan will include the formulation of goals, objectives and services to address self-identified needs of the guest. The plan will be reviewed routinely during the guest's stay to evaluate progress and the effectiveness of services provided. The services will be flexible, based on guest need and preference, and they may change as the guest's needs and desires change.

The resulting plan will guide the treatment and support relationship and be actively used by both parties in the day to day work during the guest's stay as well as informing the discharge planning process. The center staff, with authorization from the guest, will also attempt to include family members and other key supporters in the assessment and planning process.

The recovery plan will focus on three interrelated areas: the immediate wellness goal; maintenance of wellness upon discharge; and identification of future hopes, dreams, and goals among other details. Following the initial assessment, the recovery plan will identify the following:

- the guest's self-identified strengths and challenges;
- rationale for admission according to the guest;
- the immediate wellness goal and action steps;
- planning for future crisis and identification of supports (e.g. develop WRAP) and action steps;
- exploration of future hopes, dreams, goals to be worked on upon discharge
- target discharge date;
- community engagement plan following discharge

Support Services, Treatment Services and Activities

The service program is designed to achieve stabilization while maintaining social, family and community ties as outlined in the recovery plan. The services and environment shall ensure:

1. Case management activities that emphasize discharge planning;
2. Linkages with service options in the community to ensure continuation of ongoing treatment and rehabilitation; and
3. Provision of a home-like environment that supports the safety, comfort and well-being of the guests.

The respite will provide a flexible array of treatment and support services designed to assist guests in managing and moving through the current crisis, building on-going supports, and identifying personal hopes and goals. The development of a trusting and supportive relationship between the center staff and guests will be the cornerstone of the work at the respite. At the same time, it is recognized that recovery and community reintegration requires a healthy support network of friends, family, and treating professionals that will endure into the future - collaboration with existing supports and/or linkage to new community supports when needed will be an important part of the work.

To aid in the recovery process, there will be a structured menu of five to eight different services, groups, and activities scheduled throughout the day. It is envisioned that the guest will map out, through the recovery planning process, those services and activities that will be most helpful to them during their stay. While none of the services is mandatory, guests are expected to engage with staff at a level of intensity that is both comfortable and relevant to the individual recovery plan. Appendix A is a sample schedule outlining a week in the crisis respite center.

Specific support services will include:

- Helping people identify and develop coping and healing strategies and resources, which may include medication, mindfulness, cognitive behavioral tools, voice hearer support, and other wellness self-management skills.
- Information and education in a variety of areas including: nutrition, physical and mental health, community resources, medication, parenting, healthy relationships, self-advocacy, tobacco dependence, educational/vocational/employment resources, the body/mind connection, safer sex practices, relapse prevention and substance use risk reduction strategies.
- Opportunities for community building, peer support, cultural, social and spiritual enrichment.
- Guidance and assistance to guests in meeting the responsibilities of community living. This may include assistance with financial management and activities of daily living.
- Medication monitoring
- Crisis planning, including identifying early warning signs of crisis, and interventions and supports that have been useful to them in the past.
- Collaboration and coordination of services with community supports.

Specific support services will be provided by a variety of crisis respite center staff as appropriate to their role.

Treatment Services

Diagnosis and assessment; medication assessment and optimization; individual and group counseling sessions focusing on the following areas: symptom management, recovery techniques, self-help and wellness strategies, auricular acupuncture, emotion regulation techniques,

interpersonal effectiveness skills, distress tolerance techniques, mindfulness techniques, sleep hygiene, and nutrition. Treatment services will be provided by licensed clinicians.

Non-treatment activities will include: meal planning and preparation, community engagement – leisure activities, hobbies, expressive arts, current affairs discussions, opportunities for exercise, movement and relaxation such as walking, yoga, tai chi, etc.

Admission Criteria

- a principal diagnosis of a psychiatric disorder
- voluntary
- no evidence of symptoms indicative of active engagement in substance use which is manifested in a physical dependence or results in aggressive or destructive behavior
- no evidence of symptoms indicative of immediate potential or likelihood of serious harm to self or others
- short-term situational need
- not chronically homeless
- no evidence of symptoms indicative of a need for psychiatric hospitalization
- medically stable
- able to understand their rights, program goals, rules, and procedures

Discharge Planning and Criteria

Discharge planning for each guest will begin upon admission and include identification of the discharge goals and the criteria for determining the necessity and appropriateness of the guest's continued stay.

The discharge criteria will include, at least, one of the following:

1. An appropriate residential alternative to the crisis respite center has been secured on behalf of the guest;
2. A voluntary withdrawal from the program is made by the guest;
3. A guest's condition has deteriorated such that psychiatric inpatient care and treatment is required; or
4. A guest presents medical problems that require a level of care other than a crisis residence.

Respite staff will work with each guest on formulating a discharge plan that will include the following elements:

- The guest's self-care and support plan
- The target discharge date.
- The name(s) of the provider(s) responsible for post-discharge care, the location, date and time of the first appointment
- The names, dosages and frequencies of each medication and a schedule for appropriate lab tests if pharmacotherapy is a modality of post-discharge care.
- Linkages with peer services and other community resources.

- The plan to communicate all necessary clinical information to the provider(s) responsible for post-discharge care, as well as to the member's primary care provider when appropriate.
- The plan to ensure that the guest has a supply of medication sufficient to bridge the time between discharge and the scheduled follow-up psychiatric assessment.

A typical length of stay should not exceed 15 days. Lengths of stay exceeding 30 days must be documented and justified through the utilization review process.

An administrative discharge from the respite may result from the following circumstances:

1. The guest presents a likelihood of endangerment to self or others because of violent or dangerous behavior or severe drug or alcohol problems
2. The guest failure to follow the terms of the guest agreement outlining responsibilities of guests during their stay at the respite.

Utilization review

The Respite Center will establish a utilization review (UR) committee that shall be composed of at least two members of the clinical staff, one of whom must be a licensed behavioral health professional. In addition, respite center staff will work closely with referral source to review the necessity and appropriateness of the individual's continued stay in the respite center.

The UR committee will: convene meetings as often as necessary to execute its functions, but in no event less often than weekly; maintain written minutes of meetings; and submit reports to the program director.

Admissions and continued stays will be reviewed in accordance with section 589.4(a)(2) and (4) of the New York State Codes, Rules and Regulations. The utilization review committee shall review each guest's admission and continued stay in accordance with the following requirements:

- An admission and initial continued stay review shall be completed by the utilization review committee or its designee no later than three days after admission, excluding weekends.
- Subsequent continued stay reviews shall be completed by the utilization review committee or designated member of the committee within 12 days after the initial continued stay review and no later than seven days thereafter.
- Review of each alternate care determination by the utilization review committee or subcommittee of the utilization review committee
- Notification of the program director of all decisions.

Medication optimization

Medication optimization is a term that is being used by many to describe an approach to medication that where individuals receive no less and no more medications than what is optimal. The National Empowerment Center describes medication optimization as "a term used by peers, professionals,

family members and advocates calling for the adoption of sound medication prescription protocols based in shared decision-making, informed consent, and the principle of ‘do no harm.’”

In the proposed crisis respite center the term is used to signify a treatment approach where medications are used judiciously and are seen as one tool among many to aid individuals in their recovery. Medications are balanced with an array of other effective, recovery based services and supports.

Clinical Services

The clinical services provided by licensed behavioral health professional will be short term and focus on the current crisis – for example, what brought the guest to the respite center, how the guest hopes to use/is using the respite services available. This counseling is not intended to be a replacement for ongoing clinical support in the community. With guest consent, the respite clinician will be able to communicate with the any involved clinicians in the community to ensure continuity of care. The behavioral health professionals in the respite center will be licensed by the New York State Dept. of Education as an LMSW or LCSW.

The licensed staff’s use of a motivational enhancement approach together with coaching, and the use of the stages of change philosophy, will provide a recovery blueprint that the guest can take with him/her back into the community.

Staffing Highlights

PNP and RN positions

Our proposed staffing pattern does include 80 hours (2 FTE) positions to be filled by a Psychiatric Nurse Practitioner (PNP) and a RN. The PNP and RN positions will provide health assessment and overall clinical support for the staff. The psychiatric nurse will perform mental status evaluations as needed. The nurses will also provide medication management assessments and educate staff and guests about medications, symptom management techniques and side effects.

Community Health Navigator

Community health navigator essential job functions:

Identify common barriers to health care & support; develop strategies to overcome them; empower guests to develop & follow wellness habits & routines, increase awareness & understanding of community resources; provide coaching and supportive strategies for guests prior to, during, and after healthcare visits; provide linkages to services in the community; accompany guests to these appointments, as needed; train staff on available community resources and how to access them.

Experience Required for Key Positions

- The director will have a minimum of 3-5 years of management experience working in settings serving individuals diagnosed with psychiatric disabilities. Experience working

with people with behavioral health issues and who may or may not also have histories of homelessness, drug use, HIV/AIDS and other co-morbidities is preferred.

- The psychiatric nurse practitioner will have 2-5 years of experience working with people with behavioral health issues and who may or may not also have histories of homelessness, drug use, HIV/AIDS and other co-morbidities.
- The RN will have at least 2 years of nursing experience in public health, mental health or psychiatric nursing in a position requiring the provision of direct services.
- The behavioral health professionals will have 2-5 years of experience working in a clinical or rehabilitation mental health setting. Experience with people with histories of drug use, HIV/AIDS and other co-morbidities preferred.
- Respite workers will have lived experience of mental health diagnosis, and may also have experienced homelessness, struggles with drug and alcohol use, incarceration and/or trauma. Work experience in a behavioral health or related setting, preferably using the recovery model.

APPENDIX A – SAMPLE WEEKLY SCHEDULE

<u>Time</u>	<u>Monday</u>	<u>Tuesday</u>	<u>Wednesday</u>
7:30 AM-8:30 AM	Breakfast	Breakfast	Breakfast
9:00 AM-12:00PM	Individual Therapy Sessions BH Professional	Individual Therapy Sessions BH professional	Individual Therapy Sessions BH Professional
09:30 AM - 10:30 AM	Mindfulness Practice BH Professional and Peer	Yoga	Mindfulness Practice BH Professional and Peer
11:00 AM-12:15 PM	Wellness--Walking Group Peer	Nutrition Nurse and peer	Wellness--Walking Group Peer
11:30 AM - 12:00 PM	Wellness Self-Management Peer		
12:30 PM-1:15 PM	Lunch	Lunch	Lunch
1:30 PM-3:00 PM	WRAP Group Peer and/ or BH Professional	WRAP Group Peer	WRAP Group Peer and/ or BH Professional
03:00 PM-5:00 PM	Check-In With Peer Worker	Check-In With Peer Worker	Check-In With Peer Worker
4:00 PM-5:00 PM	Expressive Arts Peer		Expressive Arts Peer
5:00 PM-6:00 PM	Resource/Education Group Peer	Mindfulness Practice BH professional and Peer	Wellness Self-Management Peer
6:00 PM-7:00	Community Meal	Community Meal	Community Meal

PM			
07:00 PM - 08:00 PM			Resource/Education Group Peer
8:30 PM-9:30 PM	Peer Support Group	Peer Support Group	Peer Support Group
08:00 PM - 10:00 PM	Films/Discussions & Game Nights Peer	Films/Discussions & Game Nights Peer	Films/Discussions & Game Nights Peer
10:00 PM-6:00 AM	Quiet Hours	Quiet Hours	Quiet Hours
	<u>Thursday</u>	<u>Friday</u>	<u>Saturday/Sunday</u>
7:30 AM-8:30 AM	Breakfast	Breakfast	Breakfast
9:00 AM- 12:00PM	Individual Therapy Sessions BH professional	Individual Therapy Sessions BH Professional	Individual Therapy Sessions BH Professional
09:30 AM - 10:30 AM	Yoga Peer	Mindfulness Practice BH professional and Peer	Yoga Peer
11:00 AM- 12:15 PM	Nutrition Peer and/or RN	Wellness--Walking Group Peer	Nutrition Peer and/or RN
11:30 AM - 12:00 PM			
12:30 PM-1:15 PM	Lunch	Lunch	Lunch
1:30 PM-3:00 PM	WRAP Group Peer and/ or BH	WRAP Group Peer and/ or BH	WRAP Group Peer and/ or BH

	Professional	Professional	Professional
03:00 PM-5:00 PM	Check-In With Peer Worker	Check-In With Peer Worker	Check-In With Peer Worker
4:00 PM-5:00 PM		Expressive Arts Peer	Mindfulness Practice BH Professional and Peer
5:00 PM-6:00 PM	Mindfulness Practice BH Professional and Peer	Wellness Self- Management Peer	
6:00 PM-7:00 PM	Community Meal	Community Meal	Community Meal
07:00 PM - 08:00 PM		Resource/Education Group Peer	
8:30 PM-9:30 PM	Peer Support Group	Peer Support Group	Peer Support Group
08:00 PM - 10:00 PM	Films/Discussions & Game Nights Peer	Films/Discussions & Game Nights Peer	Films/Discussions & Game Nights Peer
10:00 PM-6:00 AM	Quiet Hours	Quiet Hours	Quiet Hours



PART 589

OPERATION OF CRISIS RESIDENCE

14 CRR-NY XIII 589 Notes

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CHAPTER XIII. OFFICE OF MENTAL HEALTH

PART 589. OPERATION OF CRISIS RESIDENCE

Current through July 31, 2011

(Statutory authority: Mental Hygiene Law, §§ 7.09, 31.04)

14 CRR-NY XIII 589 Notes

14 CRR-NY XIII 589 Notes

2011 WL 74147987

14 CRR-NY XIII 589 Notes

14 CRR-NY 589.1

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* Section 589.1. * Background and intent.

(a) The purpose of this Part is to establish standards for the operation of the crisis residence program which provides short-term residential support to mentally ill individuals at risk of inpatient hospitalization and who are experiencing either a situational or an acute psychiatric crisis.

(b) The purpose of this Part is to describe requirements for the establishment and operation of crisis residence programs; establish the requirements for admission and discharge; and specify the requirements for staffing, services, service planning, quality assurance, recordkeeping and certification.

(c) The purpose of this Part is to establish standards for two types of crisis residences: situational and acute psychiatric. Each crisis residence will meet the requirements of this Part as well as the requirements pertaining to the specific type of crisis residence set forth in Subparts 589-1, Operation of Situational Crisis Residence, and 589-2, Operation of Acute Psychiatric Crisis Residence.

(d) This Part provides for the active involvement of the family of a resident where appropriate in all aspects of the admission, treatment and discharge of that resident.

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* Section 589.2.* Legal base.

(a) Sections 7.09 and 31.04 of the Mental Hygiene Law grant the Commissioner of Mental Health ("commissioner") the power and responsibility to adopt regulations that are necessary and proper to implement matters under his or her jurisdiction and to set standards of quality and adequacy of facilities, equipment, personnel, services, records and programs for the rendition of services for the mentally ill pursuant to an operating certificate.

(b) Section 31.02 of the Mental Hygiene Law prohibits the operation of residential programs providing services for the mentally ill unless an operating certificate has been obtained from the commissioner.

(c) The Mental Hygiene Law, sections 31.05, 31.07, 31.09, 31.13 and 31.19 further authorize the commissioner or his or her representatives to examine and inspect such programs to determine their suitability and proper operation. Sections 31.15 and 31.17 authorize the commissioner to suspend, revoke, or limit any operating certificate.

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* Section 589.3.* Applicability.

(a) This Part applies to any provider of services which operates or proposes to operate a crisis residence program for the mentally ill. Such programs are a subclass of community residence, pursuant to section 1.03 of the Mental Hygiene Law.

(b) This Part applies to the operation or proposed operation of a crisis residence program for the mentally ill provided by a general hospital, as defined in article 28 of the Public Health Law.

(c) This Part applies to the operation or proposed operation of a crisis residence program for the mentally ill provided by a provider of services for the mentally ill licensed pursuant to article 31 of the Mental Hygiene Law.

(d) This Part applies to the operation or proposed operation of a crisis residence program for the mentally ill provided by a State-operated psychiatric center.

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* Section 589.4.* Definitions.

(a) General.

(1) Alternate care determination is a utilization review committee decision that another specifically identified level of care is more appropriate than the level being provided, or that care is not needed. This decision is the result of a utilization review committee evaluation of a resident, in person or through review of the resident's case record, against the criteria for admission or continued stay in the program.

(2) Admission criteria are those factors of mental disability which are identified for use in determining an individual's eligibility for admission to a crisis residence program.

(3) Clinical staff are all staff members who provide services directly to residents. Clinical staff shall include professional staff, paraprofessional staff and nonprofessional staff.

(4) Continued stay criteria are those factors which are identified for use in determining the necessity and appropriateness of the resident's continued placement in the crisis residence program. These factors shall provide the basis for determining that the resident continues to meet the admission criteria of the crisis residence program. Such evidence shall be directly observed and documented by staff of the crisis residence program.

(5) Crisis residence is a short-term residential program designed to provide housing and support services to those mentally ill individuals experiencing either a situational or acute psychiatric crisis.

(i) A Situational crisis residence provides housing and support services only to those mentally ill individuals who are experiencing a situational crisis, such as, but not limited to loss of housing, finances and family support, but are not in an acute psychiatric episode.

(ii) An acute psychiatric crisis residence provides housing and support services only to those mentally ill individuals who are experiencing an acute psychiatric crisis, can be maintained in the community for at least a part of the 24-hour day and are enrolled in an intensive day treatment program. An acute psychiatric crisis residence cannot exist without an affiliation with a certified intensive day treatment program.

(6) Discharge criteria are those factors which are identified for use in determining that a resident is no longer in need or eligible for treatment within a crisis residence program.

(7) Facility means any place in which services for the mentally ill are provided and which either requires an operating certificate under article 31 of the Mental Hygiene Law or is operated by the Office of Mental Health. In the case of a hospital as defined in article 28 of the Public Health Law, facility shall mean only that part of the hospital which is operated for the purpose of providing services for the mentally ill.

(8) Family means those members of the resident's natural family or household who regularly interact with the resident and are directly affected by, or have the capability of affecting, the resident's condition.

(9) Functional deficit means a measurable limitation in an individual's capacity to function in society which is caused by a mental disorder and is evidenced by:

(i) deficiency in personal care skills (including bathing, grooming, dressing, eating and toileting skills); or

(ii) deficiency in community living skills (including the capacity to manage money, use transportation, maintain a household, and use resources such as shops or clinics); or

(iii) marked inability to form and maintain interpersonal relationships; or

(iv) inability to maintain employment or to participate in appropriate educational activities; or

(v) impairment of the individual's ability to recognize or avoid danger.

(10) Intensive day treatment program is an ambulatory program designed to be an alternative to inpatient care and provide treatment under the direction of a physician. This program is designed for individuals presenting acute psychiatric symptomatology who are at risk of admission to an inpatient program or extended stay in an inpatient program.

(11) Likelihood of serious harm is a substantial risk of physical harm to self or other persons as manifested by recent homicidal or other violent behavior which demonstrates that the resident is dangerous to self or which places others in reasonable fear of serious physical harm.

(12) Mental illness means an affliction with a mental disease or mental condition which is manifested by a disorder or disturbance in behavior, feeling, thinking or judgment to such an extent that the person afflicted requires care, treatment and rehabilitation.

(13) Provider of services means the organization which is legally responsible for the operation of a program. The organization may be an individual, partnership, association, corporation, public agency, or a psychiatric center or institute operated by the Office of Mental Health.

(14) Self-preservation means that an individual has sufficient:

(i) capacity to recognize the physical danger of fire;

(ii) judgment to recognize when such danger requires immediate egress from the residence;

(iii) capacity to follow a prescribed route of egress; and

(iv) physical mobility to accomplish such egress.

(b) Services.

(1) Case management services are activities which link the resident to the service system and coordinate the provision of services. The objective of case management in a program for the mentally ill is continuity of care and service.

(2) Crisis services are activities in a non-inpatient setting, including the residence of an individual, that address acute emotional distress when the individual's condition requires immediate attention.

(3) Task and skill training is a no vocational activity whose purpose is to enhance a resident's age-appropriate skills necessary to facilitate the resident's ability to care for himself/ herself and to function effectively in community settings. Task and skill training activities include, but are not limited to: homemaking; personal hygiene; budgeting; shopping and the use of community resources.

(c) Staff qualifications.

(1) Alcoholism counselor is an individual who is credentialed by the New York State Division of Alcohol and Alcohol Abuse.

(2) Creative arts therapist is an individual who is currently licensed as a creative arts therapist by the New York State Education Department or who has a master's degree in a mental health field from a program approved by the New York State Education Department and registration or certification by the American Art Therapy Association or American Dance Therapy Association or National Association of Music Therapy or American Association for Music Therapy.

(3) Marriage and family therapist is an individual who is currently licensed as a marriage and family therapist by the New York State Education Department.

(4) Mental health counselor is a individual who is currently licensed as a mental health counselor by the New York State Education Department.

(5) Nurse is an individual who is currently licensed as a registered professional nurse by the New York State Education Department.

(6) Occupational therapist is an individual who is currently licensed as an occupational therapist by the New York State Education Department.

(7) Pastoral counselor is an individual who has a master's degree or equivalent in pastoral counseling and is a Fellow of the American Association of Pastoral Counselors.

(8) Physician is an individual who is currently licensed as a physician by the New York State Education Department.

(9) Psychiatrist is an individual who is currently licensed as a physician by the New York State Education Department, and is a diplomat of the American Board of Psychiatry and Neurology or is eligible to be certified by that board; or is certified by the American Osteopathic Board of Neurology and Psychiatry or is eligible to be certified by that board.

(10) Psychoanalyst is an individual who is currently licensed as a psychoanalyst by the New York State Education Department.

(11) Psychologist is an individual who is currently licensed as a psychologist by the New York State Education Department.

(12) Rehabilitation counselor is an individual who has either a master's degree in rehabilitation counseling from a program approved by the New York State Education Department, or is currently certified by the Commission on Rehabilitation Counselor Certification.

(13) Social worker is an individual who is either currently licensed as a licensed master social worker or as a licensed clinical social worker by the New York State Education Department or has a master's degree in social work from a program approved by the New York State Education Department.

(14) Therapeutic recreation specialist is an individual who has either a master's degree in therapeutic recreation from a program approved by the New York State Education Department or is currently registered as a therapeutic recreation specialist by the National Therapeutic Recreation Society.

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* Section 589.5.* Certification.

(a) Each provider of services that intends to operate a crisis residence program must be issued an operating certificate by the Office of Mental Health prior to operation of the program.

(b) Each crisis residence shall be issued an operating certificate that specifies the type of crisis residence.

(c) An operating certificate shall be issued to a provider of services to operate an acute psychiatric crisis residence program only when the acute psychiatric crisis residence serves as a residential component of an intensive day treatment program.

(d) An acute psychiatric crisis residence may not exceed 10 beds, unless it is affiliated with more than one intensive day treatment program. Acute psychiatric crisis residences which serve more than one intensive day treatment program may not exceed 20 beds.

(e) A situational crisis residence may not exceed 14 beds, unless it was in operation prior to July 1, 1987 and is approved to exceed 14 beds by the Office of Mental Health.

(f) An operating certificate may be limited, suspended, invalidated or revoked by the Office of Mental Health in accordance with the provisions of Part 573 of this Title. Operating certificates shall remain the property of the Office of Mental Health, and invalidated or revoked operating certificates shall be returned to the Office of Mental Health.

(g) Each operating certificate will specify:

(1) the location of the crisis residence program and when the crisis residence is an acute psychiatric crisis residence, the location of the affiliated intensive day treatment program;

(2) the type of crisis residence program;

(3) the term of the operating certificate;

(4) any changes to be made in the operation of the facility or program in order to retain the operating certificate; and

(5) the resident capacity of the crisis residence program.

(h) In order to receive and retain an operating certificate, a provider of services shall:

(1) submit an application on such forms and with such supporting documentation as shall be required by the Office of Mental Health;

(2) frame and display the operating certificate within the crisis residence program in a conspicuous place which is readily accessible to the public;

(3) cooperate with the Office of Mental Health during any review or inspection of the facility or program;

(4) make available to the Office of Mental Health upon request all documents, files, reports, resident records, accounting records, or other materials required by this Part or requested by the Office of Mental Health in the course of visitation, audit and inspection;

(5) undertake changes in the operation of the facility or program as required by the operating certificate; and

(6) obtain prior approval of the Office of Mental Health to:

(i) change the physical location of the program or utilize additional physical locations;

(ii) initiate major changes in the program;

(iii) terminate the program or services in the program; and

(iv) change the powers or purpose set forth in the certificate of incorporation.

(i) There shall be a written plan which establishes an explicit operational relationship between an acute crisis residence program and an intensive day treatment program. Such plan shall describe policies and procedures for administration, staff sharing and supervision. The plan shall be subject to approval by the Office of Mental Health.

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* Section 589.6.* Organization and administration.

(a) The provider of services shall identify the individual or individuals who have overall responsibility for the operation of the crisis residence program. This individual or individuals shall be known as the governing body. The governing body may delegate responsibility for the day-to-day management of the program to appropriate staff in accordance with a plan of organization approved by the Office of Mental Health. No individual shall serve as both member of the governing body and of the paid staff of the crisis residence program without prior approval of the Office of Mental Health.

(b) The provider of services shall assure that the crisis residence has space, program, staff, policies and procedures that are programmatically and physically separate from any other programs which may be operated by the provider of services.

(c) Situational and acute psychiatric crisis residences may be located in the same building and share staff provided that they are programmatically and physically separate and distinct. The Office of Mental Health will review such requests and consider waivers of individual program staffing and administrative staffing if the applicant documents:

- (1) the programmatic and physical separateness of the two programs;
- (2) appropriateness of available space;
- (3) appropriate number and mix of staff; and
- (4) appropriate administrative staffing.

(d) The governing body shall meet on a regular basis, in no event less often than quarterly, and shall maintain written minutes of all meetings as permanent record of the decisions made in relation to the operation of the crisis residence program. The minutes shall be reviewed and approved by the governing body.

(e) The governing body shall approve a written plan or plans that, at a minimum, address the following aspects of the operation of each crisis residence program:

- (1) the goals and objectives of the crisis residence program, including the admission and discharge criteria;
- (2) the plan of organization that clearly indicates lines of responsibility;
- (3) a written plan for services and staff composition which:

(i) includes the qualifications and duties of each staff position by title, and addresses all essential aspects of the operation of the crisis residence program, including clinical, administrative, fiscal, clerical, housekeeping, maintenance, dietetic, and recordkeeping and reporting functions;

(ii) specifies all services available through the crisis residence program; and

(iii) for an acute psychiatric crisis residence, specifies all services provided by the affiliated intensive day treatment program;

(4) the written quality assurance plan pursuant to section 589.10 of this Part; and

(5) the written utilization review plan pursuant to section 589.11 of this Part.

(f) The governing body shall approve written policies and procedures of the crisis residence program including but not limited to:

(1) admission and discharge policies and procedures;

(2) policies and procedures regarding the rules and regulations necessary for resident compliance for program participation;

(3) personnel policies and procedures. Such policies and procedures shall prohibit discrimination on the basis of race, color, creed, disability, national origin, sex, marital status or age and shall provide for a review of the qualifications of all clinical staff and verification of employment history, personal references and work record and determination of past convictions of a crime in New York State or any other jurisdiction;

(4) staff training and development policies and procedures. Such policies and procedures shall address orientation, ongoing training and staff development;

(5) medication policies and procedures. Such policies and procedures shall be consistent with applicable Federal and State laws and regulations;

(6) case record policies and procedures. Such policies and procedures shall ensure confidentiality of resident records in accordance with section 33.13 of the Mental Hygiene Law, and shall ensure appropriate retention of case records; and

(7) policies and procedures related to performing the services provided by the crisis residence program.

(g) The governing body shall review the written plan or plans and policies and procedures required pursuant to subdivisions (e) and (f) of this section at least annually, and shall make appropriate amendments or revisions.

(h) The governing body shall delegate responsibility for the day-to-day management of the crisis residence program in accordance with the written plan of organization provided for in paragraph (e)(2) of this section.

(1) Onsite direction shall be delegated to an individual who shall be known as the director and who shall meet the qualifications specified in section 589.8(d) of this Part.

(2) The director shall be employed by the crisis residence program as a full-time employee.

(3) Overall administrative direction may be the responsibility of the director or may be delegated by the governing body to an individual who shall meet qualifications that are acceptable to the Office of Mental Health.

(i) There shall be a special review committee that includes at least two members of the clinical staff, one of which must be a professional staff member. The committee shall:

(1) develop a written special review plan, pursuant to section 589.10(c) of this Part which shall provide for review of all untoward incidents;

(2) review and evaluate untoward incidents in accordance with the plan, excluding from the committee's final deliberation those committee members who were present when the untoward incident occurred;

(3) determine the facts in any untoward incident reported, review ongoing practices and procedures in relation to such incidents, and recommend to the director changes in policies, practices, and procedures or recommend such other action as may be indicated; and

(4) meet as often as necessary to properly execute its functions and in no event less often than quarterly, keeping written minutes of its deliberations and submitting reports to the director as necessary.

(j) The crisis residence program shall participate with the local governmental unit in local planning processes. At a minimum, participation shall include:

(1) provision of budgeting and planning data as requested by the local governmental unit;

(2) identification of the population being served by the crisis residence program;

(3) identification of the geographic area being served;

(4) description of the relationship to other providers of services which serve the same geographic area including, but not limited to, written agreements to ensure expeditious access to programs by persons who need them. At a minimum, these agreements shall provide for prompt referral, evaluation, and, as necessary, admission to cooperating programs, and for sharing information about patients being served; and

(5) attendance at planning meetings as may reasonably be required by the local governmental unit.

(k) The crisis residence program shall provide for the following:

(1) an annual written evaluation of the crisis residence program's attainment of its stated goals and objectives including any required changes in policies and procedures;

(2) in programs which are not State- or local government-operated, an annual audit of the financial condition and accounts of the crisis residence program must be performed by a certified public accountant who is not a member of the governing body or an employee of the crisis residence program or the provider of service. Government-operated programs shall comply with applicable laws concerning financial accounts and auditing requirements. The audit may be program specific or may be performed as part of an overall facility audit;

(3) emergency evacuation plans for the building in which the crisis residence program is located. Evacuation plans shall address emergencies resulting from fire as well as potential hazards in the geographic area in which the crisis residence program is located; and

(4) up-to-date copies of any regulations, guidelines, manuals or other information required by the Office of Mental Health.

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* Section 589.7.* Written plan for services and staff composition.

(a) Each crisis residence program shall develop and specify in a written plan for services and staff composition its goals and objectives and the manner in which it intends to achieve them. The written plan for services and staff composition shall be subject to approval by the Office of Mental Health.

(b) The written plan for services and staff composition shall address the comprehensive service needs of the residents.

(c) The written plan for services and staff composition shall encompass the following written plans and rationales required under this Part:

(1) services required to be available through the crisis residence program;

(2) service program and environment addressing the day-to-day activities of the residents; and

(3) staffing required to provide services and day-to-day management and monitoring of the crisis residence program.

(d) The written plan for services and staff composition shall address the manner in which the staff will integrate the services available through the crisis residence program into an individual service plan designed to meet the needs of each resident and include involvement of the family as appropriate.

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* Section 589.8. * Staffing.

(a) A crisis residence program shall continuously employ an adequate number of staff and an appropriate staff composition to carry out its goals and objectives as well as to ensure the continuous provision of sufficient ongoing and emergency supervision. As a component of the written plan for services and staff composition, the crisis residence program shall submit a staffing plan which includes the qualifications and duties of each staff position, by title. The crisis residence program shall submit a written staffing rationale which justifies the staff to be used, the composition of staff and the plan for appropriate supervision and training. This staffing plan shall be based on the population to be served and the services to be provided. Depending upon the category of crisis residence, the plan must meet the requirements of sections 589-1.4 or 589-2.4 of this Part. The staffing plan and its rationale shall be subject to approval by the Office of Mental Health.

(b) All clinical staff must have at least a high-school diploma or its equivalent.

(c) At least 50 percent of the clinical staff hours shall be provided by full-time employees of the crisis residence program.

(d) For the purposes of this Part, professional staff are individuals who are qualified by training and experience to provide direct services under minimal supervision.

(1) Professional staff may include the following as defined in section 589.4 of this Part:

- (i) alcoholism counselor;
- (ii) creative arts therapist;
- (iii) nurse;
- (iv) occupational therapist;
- (v) pastoral counselor;
- (vi) physician;
- (vii) psychiatrist;
- (viii) psychologist;
- (ix) rehabilitation counselor;
- (x) social worker;

- (xi) therapeutic recreation specialist;
- (xii) marriage and family therapist;
- (xiii) mental health counselor; and
- (xiv) psychoanalyst.

(2) Other professional disciplines may be included as professional staff provided that the discipline is approved as part of the staffing plan by the Office of Mental Health. The discipline shall be from a field related to the treatment of mental illness. The individual must be licensed in such discipline by the New York State Education Department, and shall have specialized training or experience in treating the mentally ill.

(e) All staff shall have qualifications appropriate to assigned responsibilities as set forth in the staffing plan and shall practice within the scope of their professional discipline and/or assigned responsibility. All staff shall submit documentation of their training and experience to the crisis residence program. Such documentation shall be verified and retained on file by the crisis residence program.

(f) Students or trainees may qualify as clinical staff under the following conditions:

(1) the students and trainees are actively participating in a program leading to attainment of a recognized degree or certificate in a field related to mental health at an institution chartered or approved by the New York State Education Department. Limited-permit physicians are considered students or trainees;

(2) the students or trainees are supervised and trained by professional staff meeting the qualifications specified in this section, and limited-permit physicians are supervised by physicians;

(3) the students or trainees use titles that clearly indicate their status; and

(4) written policies and procedures pertaining to the integration of students and trainees within the overall operation of the crisis residence program shall receive approval by the Office of Mental Health.

14 CRR-NY 589.8
14 CRR-NY 589.8
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14 CRR-NY 589.8

14 CRR-NY 589.9

OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS OF THE STATE OF NEW YORK

TITLE 14. DEPARTMENT OF MENTAL HYGIENE

CHAPTER XIII. OFFICE OF MENTAL HEALTH

PART 589. OPERATION OF CRISIS RESIDENCE

Current through July 31, 2011

* Section 589.9.* Individual service plans.

(a) An individual service plan shall be developed and implemented for each resident by the staff of the crisis residence.

(b) The individual service plan shall be based on a comprehensive assessment of each resident.

(1) The assessment shall include, but shall not be limited to, physical, medical, emotional, behavioral, social, residential, recreational and, when appropriate, vocational and nutritional needs. If appropriate, this information, with the resident's consent, may be obtained from the resident's most recent mental health service provider(s).

(2) Consideration of each resident's needs shall include a determination of the type and extend of additional clinical examinations, tests and evaluations necessary for a complete assessment.

(c) The individual service plan shall address the needs of the resident.

(1) The individual service plan shall identify all service needs of the resident, whether or not the services are provided directly by the crisis residence program.

(2) The individual service plan shall address the manner in which the family, as appropriate, will be involved in the service planning and implementation.

(3) For an acute psychiatric crisis residence, the individual service plan shall be coordinated with and consistent with the resident's treatment plan developed in the affiliated intensive day treatment program.

14 CRR-NY 589.9

14 CRR-NY 589.9

2011 WL 74148004

14 CRR-NY 589.9

14 CRR-NY 589.10

OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS OF THE STATE OF NEW YORK

TITLE 14. DEPARTMENT OF MENTAL HYGIENE

CHAPTER XIII. OFFICE OF MENTAL HEALTH

PART 589. OPERATION OF CRISIS RESIDENCE

Current through July 31, 2011

* Section 589.10.* Quality assurance.

(a) Each crisis residence program shall have an organized quality assurance program designed to enhance resident care through the ongoing objective assessment of important aspects of resident care and the correction of identified problems. The quality assurance program shall provide for the following:

(1) identification of problems or concerns related to the care of residents including but not limited to resident compliance with the individual service plan;

(2) objective assessment of the cause and scope of the problems or concerns, including the determination of priorities for both investigating and resolving problems and concerns. Priorities shall be related to the degree of adverse impact on the care provided to residents that can be expected if the problems or concerns remain unresolved;

(3) recommendations related to implementation of decisions or actions that are designed to eliminate, insofar as possible, identified problems; and

(4) monitoring to assess whether or not the desired result has been achieved and sustained.

(b) Each crisis residence program shall prepare a written quality assurance plan designed to ensure that there is an ongoing quality assurance program that includes effective mechanisms for reviewing and evaluating resident care and provides for appropriate response to findings. This quality assurance plan shall be subject to approval by the Office of Mental Health. The quality assurance plan may be program-specific or part of an overall facility quality assurance plan. The written quality assurance plan shall address at a minimum:

(1) the individual or group with the overall responsibility to administer or coordinate the quality assurance program;

(2) the individuals or organizational entities to whom responsibility will be delegated for specific activities or mechanisms;

(3) the activities or mechanisms for reviewing and evaluating resident care;

(4) the activities or mechanisms for assuring the accountability of the clinical staff for the care they provide;

(5) the individuals or organizational entities to whom responsibility will be delegated for responding to findings or implementing corrective actions designed to eliminate, insofar as possible, identified problems; and

(6) the activities or mechanisms for monitoring whether or not the corrective actions have been implemented, and whether or not the desired result has been achieved and sustained.

(c) As a component of the quality assurance program each crisis residence program shall establish a written plan for reviewing untoward incidents. Untoward incidents include, but are not limited to, serious drug reactions, suicide attempts, suicides, homicides and sudden deaths, assaults, alleged abuse of residents, accidents and terminations of service against professional advice when such termination presents a risk of hospitalization or danger to the resident or others. This plan shall be subject to approval by the Office of Mental Health. The written plan for reviewing untoward incidents shall address at a minimum:

(1) the establishment of a special review committee that shall include at least two members of the clinical staff to meet the qualifications provided in section 589.4(a)(3) of this Part; one of which must be a professional staff member. The special review committee shall include a physician as required;

(2) the review of all untoward incidents by the special review committee to determine the facts in any untoward incident reported, and to review ongoing practices and procedures in relation to such untoward incidents;

(3) the operating procedures of the special review committee, including: convening meetings as often as necessary to execute its functions, but in no event less often than quarterly; maintaining written minutes of meetings; and submitting reports to the director. Special review committee members who were present when the untoward incident occurred shall be excluded from the committee's final deliberations;

(4) the proper reporting of all deaths and untoward incidents in accordance with the Mental Hygiene Law and Part 24 of this Title; and

(5) the integration of the plan for reviewing untoward incidents into the overall quality assurance program.

14 CRR-NY 589.10
14 CRR-NY 589.10
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14 CRR-NY 589.10

14 CRR-NY 589.11

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TITLE 14. DEPARTMENT OF MENTAL HYGIENE

CHAPTER XIII. OFFICE OF MENTAL HEALTH

PART 589. OPERATION OF CRISIS RESIDENCE

Current through July 31, 2011

* Section 589.11.* Utilization Review.

(a) The crisis residence program shall have an organized utilization review process designed to monitor the appropriateness of admission and continued stay and to identify the over-utilization or under-utilization of services.

(b) The crisis residence program shall prepare a written utilization review plan designed to ensure that there will be an ongoing utilization review program. The utilization review plan may be program-specific or part of an overall facility utilization review plan. This utilization review plan shall be subject to approval by the Office of Mental Health.

14 CRR-NY 589.11
14 CRR-NY 589.11
2011 WL 74148008
14 CRR-NY 589.11

OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS OF THE STATE OF NEW YORK

TITLE 14. DEPARTMENT OF MENTAL HYGIENE

CHAPTER XIII. OFFICE OF MENTAL HEALTH

PART 589. OPERATION OF CRISIS RESIDENCE

Current through July 31, 2011

* Section 589.12.* Premises.

(a) The crisis residence shall be safe and suitable for the comfort and care of the persons resident therein. The residence shall be maintained in a good state of repair and sanitation.

(b) Safety requirements. The crisis residence shall meet the following requirements:

(1) A sufficient number of fire extinguishers, approved by the Underwriters Laboratories, shall be installed in accessible places on each floor and in high-hazard areas. Fire extinguishers shall be tested and recharged in accordance with manufacturers' recommendations.

(2) Employees shall be trained in the use of firefighting equipment, and in the means of rapidly evacuating the building. Fire exit drills shall be held at least once per month and at varied times during the 24 hours. A written record of each drill shall be kept on file for a period of one year.

(3) All of the following fire hazards are prohibited:

(i) space heaters;

(ii) the use of kerosene for cooking or lighting;

(iii) rubber tubing used as connections for gas burners;

(iv) the accumulation of combustible material in attics, basements or other parts of the residence; and

(v) unsafe storage of paints, varnishes, oils, and other combustible liquids.

(4) Each crisis residence shall have a smoke-detection system which meets the requirements of section 6-3 of the Life Safety Code 101 of the National Fire Protection Association, applicable to noncoded systems, and the following:

(i) A smoke-detection unit shall be located in each stairway at each floor, in each bedroom, in each 1,000 square feet of unoccupied attic and basement space, in each high hazard area, and in each 40 feet or part thereof of corridor length.

(ii) Location of smoke-detection units shall be subject to Office of Mental Health approval.

(iii) The smoke-detection system or each independently operating unit shall be tested at least once each three-month period, and batteries in battery-operated units shall be replaced as necessary.

(iv) A complete system or individual units may be required depending on the construction, layout, occupancy and/or other factors associated with the building. Prior to the opening of a crisis residence,

and the issuance of an operating certificate, a fire safety plan must be submitted to and approved by the Office of Mental Health.

(c) Design and space requirements.

(1) Single bedrooms shall be at least 90 square feet (exclusive of closets) and a multiple bedroom shall provide at least 75 square feet per resident.

(i) No more than four persons shall share a bedroom.

(ii) No bedroom shall be located below grade.

(iii) Up to 15 percent of minimum square footage may be waived for cause in bedrooms housing one or two persons. Consideration will also be given to the amount of square footage per resident in living, dining and recreational areas. Requests for such waivers should be outlined in the fire safety plan submitted to the Office of Mental Health.

(2) There shall be a minimum of one toilet, one lavatory and one tub or shower for each five residents or part thereof.

(3) In addition to bedroom space, at least 55 square feet of space per resident shall be provided for living, dining and recreational activities, apportioned within at least two distinct areas in each crisis residence unit.

(i) Dining rooms shall be equipped to provide for small group seatings during meals.

(ii) Living rooms and/or recreation areas shall provide for small group socialization and recreation.

(d) Equipment shall include:

(1) suitable, comfortable, single beds and an adequate supply of clean linen. Cots must not be used. High hospital-type beds shall not be used except for physically handicapped persons requiring them;

(2) a chair and storage facility for personal articles for each resident; and

(3) an individual clothes closet or wardrobe for each resident.

(e) A crisis residence serving persons who are not capable of self-preservation as defined in section 589.4 of this Part, shall comply with all requirements of chapter 10 of the Life Safety Code 101 of the National Fire Protection Association, applicable to residential-custodial occupancies, except for the fire-resistivity requirements for one-story construction, and the State Uniform Fire Prevention and Building Code (9 NYCRR), applicable to occupancy group C6.2.

(f) Crisis residences serving only persons capable of self-preservation operated in buildings without other occupancy shall meet the following requirements:

(1) If the building houses no more than 14 persons (including patients and staff who sleep at the residence), the premises shall comply with all applicable requirements of the State Uniform Fire Prevention and Building Code (9 NYCRR) applicable to one- and two-family dwellings. In addition to these requirements, the premises shall have an automatic sprinkler system and two means of egress, at least one of which is an enclosed interior stair.

(2) If the building houses more than 14 persons, the premises shall comply with all applicable requirements of the State Uniform Fire Prevention and Building Code (9 NYCRR) applicable to multiple dwellings. In addition to these requirements, the premises shall have an enclosed interior stair as a means of egress and an automatic sprinkler system.

(3) In lieu of paragraphs (1) and (2) of this subdivision, the requirements of the State Uniform Fire Prevention and Building Code (9 NYCRR) applicable to occupancy group C6.2 may be met.

14 CRR-NY 589.12

14 CRR-NY 589.12

2011 WL 74148010

14 CRR-NY 589.12

14 CRR-NY 589.13

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TITLE 14. DEPARTMENT OF MENTAL HYGIENE

CHAPTER XIII. OFFICE OF MENTAL HEALTH

PART 589. OPERATION OF CRISIS RESIDENCE

Current through July 31, 2011

* Section 589.13.* Statistical records and reports.

(a) Such statistical information shall be prepared and maintained as may be necessary for the effective operation of the crisis residence program and as may be required by the Office of Mental Health.

(b) Statistical information shall be reported to the Office of Mental Health in a manner and within time limits specified by the Office of Mental Health.

(c) Statistical reporting shall be the responsibility of an individual whose name and title shall be made known to the Office of Mental Health.

(d) Summaries of statistical information shall be reviewed at least annually as part of the annual evaluation process.

14 CRR-NY 589.13

14 CRR-NY 589.13

2011 WL 74148012

14 CRR-NY 589.13

14 CRR-NY 589-1.1

OFFICIAL COMPILATION OF CODES, RULES AND REGULATIONS OF THE STATE OF NEW YORK

TITLE 14. DEPARTMENT OF MENTAL HYGIENE

CHAPTER XIII. OFFICE OF MENTAL HEALTH

PART 589. OPERATION OF CRISIS RESIDENCE

SUBPART 589-1. OPERATION OF SITUATIONAL CRISIS RESIDENCE

Current through October 15, 2011

* Section 589-1.1.* Admission and discharge criteria.

(a) Each situational crisis residence program shall maintain written admission and discharge criteria which are consistent with its goals and objectives and which are subject to the approval of the Office of Mental Health.

(b) The admission criteria must, at a minimum, provide that the individual meet each of the following criteria:

(1) a principal diagnosis, admitting diagnosis or provisional diagnosis of a mental disorder with psychotic features, as specified in DSM III or ICD-9; or a principal diagnosis, admitting diagnosis, or provisional diagnosis of a mental disorder without psychotic features, as specified in DSM III or ICD-9 but with substantiation of a functional deficit pursuant to section 589.4(a)(9) of this Part. Such diagnosis may be made by program staff, the referral source staff, or with the resident's consent, from the resident's most recent mental health service provider;

(2) evidence indicative that a situational crisis is being experienced;

(3) no evidence of symptoms indicative of active engagement in substance abuse which is manifested in a physical dependence or results in aggressive or destructive behavior;

(4) no evidence of symptoms indicative of immediate potential or likelihood of serious harm to self or others;

(5) medical suitability for the program;

(6) no evidence of symptoms indicative of a need for psychiatric hospitalization; and

(7) competent to understand the policies and procedures for resident compliance necessary for participation in the situational crisis residence program.

(c) The discharge criteria must relate to the necessity and appropriateness of the resident's continued stay in the situational crisis residence program.

(d) The discharge criteria must, at a minimum, include one of the following criteria:

(1) an appropriate residential alternative to the situational crisis residence has been secured on behalf of the resident;

(2) a voluntary withdrawal from the program is made by the resident;

(3) a resident's condition has deteriorated such that psychiatric inpatient care and treatment is required; or

(4) a resident presents medical problems which require a level of care other than a situational crisis residence.

(e) Discharge from the situational crisis residence program may also be the result of the following circumstances:

(1) the resident presents a likelihood of endangerment to self or others because of violent or dangerous behavior or severe drug or alcohol problems; or

(2) the resident refuses to follow the rules and requirements for participation in the situational crisis program, despite efforts by the program staff to enlist such participation as documented in the case record.

14 CRR-NY 589-1.1

14 CRR-NY 589-1.1

2011 WL 74148016

14 CRR-NY 589-1.1

14 CRR-NY 589-1.2

* Section 589-1.2.* Admission and discharge policies and procedures.

(a) Written admission and discharge policies and procedures, maintained as required in section 589-1.1 of this Subpart shall:

(1) specify that admission and discharge shall be based on the written criteria established pursuant to section 589-1.1 of this Subpart;

(2) prohibit discrimination solely on the basis of race, color, creed, disability, national origin, sex, marital status or age;

(3) require that the necessity and appropriateness of each resident's admission and continued stay in the program be regularly evaluated;

(4) be available to the staff, residents and their families, cooperating agencies and the general public; and

(5) require that discharge planning for each resident begin upon admission and include, at a minimum, identification of the discharge goals and the criteria for determining the necessity and appropriateness of the resident's continued stay.

(b) The typical length of stay should not exceed 21 days. Lengths of stay exceeding 30 days must be documented and justified through the utilization review process.

14 CRR-NY 589-1.2

14 CRR-NY 589-1.2

2011 WL 74148020

14 CRR-NY 589-1.2

* Section 589-1.3.* Service requirements.

(a) As a component of the written plan for services and staff composition, the situational crisis residence program shall provide a written plan and rationale for the services available which shall be subject to approval by the Office of Mental Health. The written plan shall indicate what services will be available, and whether the situational crisis residence will provide the services directly or through a written agreement with a provider of services.

(b) The services available through the situational crisis residence include, but are not limited to, the services listed below. These services must be provided directly by the situational crisis residence program:

- (1) room and board;
- (2) assistance in personal care and daily living activities;
- (3) case management;
- (4) health care and medication monitoring;
- (5) social and leisure activities;
- (6) counseling; and
- (7) crisis management.

(c) The physical health services available through the situational crisis residence program shall include, but are not limited to the services listed below. Physical health services may be provided by written agreement as provided for in subdivision (d) of this section.

- (1) A physical examination upon admission and treatment as needed.
- (2) Emergency physical health care on a 24-hour basis.

(d) When physical health services are not provided directly by the situational crisis residence, there shall be a written agreement between a provider of services and the situational crisis residence program. When physical health services are provided by the situational crisis residence program, written policies and procedures are required. The written agreement shall, at a minimum, address:

- (1) referral of residents;
- (2) qualifications of staff providing services;
- (3) exchange of clinical information;
- (4) financial arrangements; and
- (5) statement of services to be provided.

(e) The situational crisis residence program shall ensure that, if appropriate, offsite psychiatric rehabilitation and treatment services are made available to the resident. Such services shall include but are not limited to the following:

(1) outpatient treatment including day treatment, continuing treatment, clinic treatment and/or other clinical services;

(2) vocational and prevocational training;

(3) day training and activity services;

(4) psychosocial supports; and

(5) substance abuse and/or alcohol abuse treatment and counseling services.

(f) Psychiatric rehabilitation and treatment services shall be provided through written agreement between a provider of such services operated or certified by the Office of Mental Health and the situational crisis residence. The written agreement shall, at a minimum, address:

(1) referral of residents;

(2) qualifications of staff providing services;

(3) exchange of clinical information;

(4) financial arrangements; and

(5) statement of services to be provided.

(g) The situational crisis residence program must have a written agreement for the provision of emergency psychiatric services with a provider of inpatient psychiatric services operated or certified by the Office of Mental Health.

14 CRR-NY 589-1.3

14 CRR-NY 589-1.3

14 CRR-NY 589-1.4

*** Section 589-1.4.* Staffing.**

(a) In order to assure that the situational crisis residence employs an adequate number of staff to ensure the health and safety of individuals residing in the program, the staffing plan shall meet each of the following requirements:

(1) At least two full-time equivalent staff shall be assigned direct care responsibility during all waking hours.

(2) At least one full-time equivalent staff shall be assigned direct care responsibilities, be awake and continuously available to the residents during all hours the residents are asleep.

(3) Appropriate professional staff shall be available to assist in emergencies on at least an on-call basis at all times.

(b) In order to assure that an adequate number of professional staff are qualified by training and experience to provide clinical supervision and program direction, the situational crisis residence shall employ at a minimum the following staff:

(1) one full-time equivalent registered nurse; and

(2) one additional full-time equivalent professional staff person.

(c) A situational crisis residence shall comply with all additional staffing requirements set forth in section 589.8 of this Part.

14 CRR-NY 589-1.4

14 CRR-NY 589-1.4

2011 WL 74148024

14 CRR-NY 589-1.4

* Section 589-1.5.* Service program and environment.

(a) The service program and environment shall be designed to provide for stabilization of the resident who is experiencing a situational crisis and to decrease the resident's disability while maintaining social, family and community ties which are integral to the individual service plan. The service program and environment shall ensure:

- (1) integration of direct care and support services;
 - (2) case management activities which emphasize discharge planning;
 - (3) linkages with service options in the community which provide continuation of ongoing treatment and rehabilitation; and
 - (4) provision of a residential environment which supports the safety, comfort and well-being of the resident.
- (b) As a component of the written plan for services and staff composition, the situational crisis residence program shall provide a written plan and a rationale for the service program and environment which shall be subject to the approval by the Office of Mental Health and addresses, at a minimum, the following:
- (1) the manner in which the service program and environment will be implemented. Implementation must be consistent for all residents yet the program must be sufficiently flexible to accommodate the needs of individual residents;
 - (2) the manner in which the service program and environment will be explained to the residents and their families upon admission;
 - (3) the day-to-day routines that the residents and staff will follow;
 - (4) the house rules of the residence and the response the resident can expect if he/she either complies or fails to comply with them. This shall include limitations on activities or other actions specified by the resident's service plan; and
 - (5) the means of providing restitution or reimbursement for damages to property of the resident, other residents, and the situational crisis residence.

14 CRR-NY 589-1.5
14 CRR-NY 589-1.5
2011 WL 74148025
14 CRR-NY 589-1.5

14 CRR-NY 589-1.6

* Section 589-1.6.* Case record.

(a) There shall be a complete case record maintained at one location for each resident admitted to the situational crisis residence. The case record shall be confidential, and access shall be governed by the requirements of sections 33.13 and 33.16 of the Mental Hygiene Law.

(b) The case record shall be available to all clinical staff of the situation crisis residence involved in the care and treatment of the resident.

(c) Each case record shall include:

(1) identifying information about the resident and the resident's family;

(2) a note upon admission indicating source of referral, date of admission, rationale for admission, the date service commenced, presenting problem and initial treatment needs of the resident;

(3) summary of psychiatric, medical, emotional, social and residential needs. Special consideration shall be given to the role of the resident's family in each area of assessment;

(4) summary of reports of all mental and physical diagnostic examinations and assessments, including findings and conclusions;

(5) summary of reports of all special studies performed, including but not limited to X-rays, clinical laboratory tests, psychological tests, and electroencephalograms;

(6) a service plan, which shall be developed within three days of the individual's admission to the program;

(7) progress notes which relate to the goals and objectives of the service plan, which shall be signed by the staff member who provided the service or by one participating staff member when several staff members have had significant interaction with the resident. Progress notes should be written at least weekly;

(8) whenever a significant event occurs that affects, or potentially affects the resident's condition, progress notes shall be written;

(9) summaries of service plan reviews and special consultations regarding all aspects of the resident's daily program;

(10) dated and signed orders which indicate commencement and termination dates for all medications; and

(11) a discharge summary, prepared within three days of discharge, which includes the reasons for discharge and, if appropriate, the provision for alternative services which the resident may require.

(d) The service plan shall include:

(1) diagnosis or diagnostic impression;

(2) a brief description of the resident's problems, strengths, conditions, disabilities, precipitating factors and needs;

(3) objectives relating to the resident's problems, conditions, disabilities and needs, and the services and staff actions which will be implemented to accomplish these objectives;

(4) discharge goals and criteria for determining the necessity and appropriateness of the resident's continued stay;

(5) identification of the staff members who will provide the specified services, activities and case management;

(6) documentation of participation by the resident in the development of the service plan and by the resident's family and representatives from the resident's treatment or rehabilitation program as appropriate; and

(7) date for the next scheduled review of the service plan. Service plan reviews should be scheduled at least on a weekly basis.

(e) Information necessary to complete and/or update the case record and service plan may be obtained from program staff, referral source staff, and/or with the resident's consent, outside medical and psychiatric staff including the resident's most recent mental health service provider. Information from outside sources must be secured within three working days of the resident's admission and must have been obtained within the previous three months. If outside information is not available, situational crisis residence staff must conduct and/or arrange to have conducted the required assessments.

14 CRR-NY 589-1.7

* Section 589-1.7.* Utilization review.

(a) Each situational crisis residence shall establish a utilization review committee that shall be composed of at least two members of the clinical staff one of whom must be a professional staff member.

(b) The utilization review committee shall: convene meetings as often as necessary to execute its functions, but in no event less often than weekly; maintain written minutes of meetings; and submit reports to the director.

(c) Admission and continued stays shall be reviewed in accordance with section 589.4(a)(2) and (4) of this Part.

(d) The utilization review committee shall review each resident's admission and continued stay in accordance with the following requirements:

(1) An admission and initial continued stay review shall be completed by the utilization review committee or its designee no later than three days after admission, excluding weekends.

(2) Subsequent continued stay reviews shall be completed by the utilization review committee or a designated member of the committee within 12 days after the initial continued stay review and no later than seven days thereafter.

(3) Review of each alternate care determination by the utilization review committee or a subcommittee of the utilization review committee.

(4) Notification of the director of final adverse decisions.

14 CRR-NY 589-1.7

14 CRR-NY 589-1.7

2011 WL 74148028

14 CRR-NY 589-1.7





SAN FRANCISCO MENTAL HEALTH BOARD

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MEETING OF THE MENTAL HEALTH BOARD

Wednesday, November 13, 2013

City Hall

One Carlton B. Goodlett Place

2nd Floor, Room 278

6:30 PM – 8:30 PM

Call to Order

Roll Call

Agenda Changes

Item 1.0 Directors Report

For discussion.

GOVERNMENT
DOCUMENTS DEPT

NOV - 7 2013

SAN FRANCISCO
PUBLIC LIBRARY

1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

1.2 Public Comment

Item 2.0 Mental Health Service Act Updates and Public Hearings

For discussion.

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Updates

2.2 Public Comment

Item 3.0 Action Items

For discussion and action.

3.1 Public comment

3.2 Proposed Resolution: Be it resolved that the minutes for the Mental Health Board meeting of October 9, 2013 be approved as submitted.

Item 4.0 Presentation: Crisis Services After Dark on the Streets of San Francisco: Night Ministry, Lyle Beckman

4.1 Presentation: Crisis Services After Dark on the Streets of San Francisco Night: Ministry, Lyle Beckman

4.2 Public Comment

Item 5.0 REPORTS

For discussion

5.1 Report from the Executive Director of the Mental Health Board.

Discussion regarding upcoming events, conferences, or activities that may be of interest to board members; Mental Health Board budget issues and update on staff work on board projects.

5.2 Report of the Co-Chairs of the Board and the Executive Committee.

Discussion regarding Chair's meetings with Community Behavioral Health Services staff, meetings with members of the Board of Supervisors and community meetings about mental health or substance abuse.

5.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

5.4 Report by members of the Board on their activities on behalf of the Board.

5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

5.6 Public comment.

6.0 PUBLIC COMMENT

ADJOURNMENT

DISABILITY ACCESS

1. Room 278 is accessible to persons using wheelchairs and others with disabilities. Assistive listening devices, materials in other alternative formats, American Sign Language interpreters and other accommodations will be made available upon request. Please contact Darlene Daevu, Community Behavioral Health Services, 415-255-3426 or by email: Darlene.daevu@sfdph.org. Providing at least 72 hours notice will help to

ensure availability. To reach a TTY line, call (415) 255-3449. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. Meetings are held at City Hall, One Dr. Carlton B. Goodlett Place (between Grove and McAllister), in Room 278. The closest accessible BART station is the Civic Center station, at the intersection of Market, Grove and Hyde Streets. The closest Muni Metro station is the Van Ness Station. Accessible MUNI lines serving the location are the 9 San Bruno, 47 Van Ness, and 71 Haight/Noriega. Also, the J, K, L, M, and N lines underground. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. Special Hearings are usually held at the Department of Public Health, 101 Grove Street, 3rd Floor, Room 300. The same public transportation options as above apply. It is wheelchair accessible.

4. For Special Hearings at other locations, please call for directions or bus information. All locations will be accessible.

5. City Hall is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room are wheelchair accessible. Accessible curbside parking has been designated on One Dr. Carlton B. Goodlett Place.

6. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

POLICY ON CELL PHONE, PAGERS, AND ELECTRONIC DEVICES

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Government's duty is to serve the public, reaching its decisions in full view of the public. Commissions, boards, councils and other agencies of the City and County exist to conduct the people's business. This ordinance assures that deliberations are conducted before the people and that City operations are open to the people's review. For more information on your rights under the Sunshine Ordinance (Chapter 67 of the San Francisco Administrative Code) or to report a violation of the ordinance, contact:

Sunshine Ordinance Task Force
City Hall, Room 244

1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: sotf@sfgov.org

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from the Task Force or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: www.sfgov.org/sunshine

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: www.sfgov.org/mental_health. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

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Individuals and entities that influence or attempt to influence local legislative or administrative action may be required by the San Francisco Lobbyist Ordinance [SF Campaign & Governmental Conduct Code 2.100] to register and report lobbying activity. For more information about the Lobbyist Ordinance, please contact the San Francisco Ethics Commission at 30 Van Ness Avenue, Suite 3900, San Francisco, CA 94102; telephone (415) 581-2300; fax (415) 581-2317; web site www.sfgov.org/ethics



Edwin Lee
Mayor

SAN FRANCISCO MENTAL HEALTH BOARD

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Unadopted Minutes

Mental Health Board
Wednesday, November 13, 2013
City Hall
One Carlton B. Goodlett Place
2nd Floor, Room 278
San Francisco, CA

BOARD MEMBERS PRESENT: David Elliott Lewis, Ph D, Co Chair; Ellis Joseph, MBA, Co Chair; Wendy James, Vice Chair; Terry Bohrer, RN, MSW, CLNC; Virginia S. Lewis, MA, LCSW, Secretary; Sgt. Kelly Kruger; Kara Chien, JD; Lena Miller, MSW; Andre Moore; Terence Patterson, EdD, ABPP; and Alphonse Vinh, MS.

BOARD MEMBERS ON LEAVE: Melody Daniel, MFT; and Errol Wishom.

BOARD MEMBERS ABSENT: none.

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jo Robinson, Director of Community Behavioral Health Services (CBHS); Reverence Lyle J. Beckman, Night Ministry; Reverence Deacon Diana Wheeler, Night Ministry; Simbareshe Temba Hove, RN at CPMC; Paul Hickman, Family Service Agency of San Francisco; Crystal R. Marsonia, ASW at Westside Community Services; Amaz Nigusse, ACSW at Westside Community Services; Simone Echeguren; Bailey Wendzel, Program Coordinator at National Alliance on Mental Illness (NAMI-SF) and two members of the public.

CALL TO ORDER

Mr. Joseph called the meeting of the Mental Health Board to order at 6:35 PM.

ROLL CALL

Ms. Brooke called the roll.

AGENDA CHANGES

There were no changes to the agenda.

ITEM 1.0 DIRECTOR'S REPORT

JAN - 6 2014

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1.1 Discussion regarding Community Behavioral Health Services Department Report, a report on the activities and operations of Community Behavioral Health Services, including budget, planning, policy, and programs and services.

Ms. Robinson, Director of CBHS, gave the November 2013 director's report. She said the department of public health is busy with implementing the Affordable Care Act (ACA) or MediCal expansion, and the new health delivering system will be San Francisco Health Network.

The public health department is moving forward with implementing a trauma informed care (TIS) workforce, and has hired Katie Speziale to organize staff training starting in February 2014.

She mentioned that Roban San Miguel from Mission Family Center was promoted to Clinic Director.

She informed the board that mental health and substance use disorder parity was created, as reported in the media. This process took several years in the making, and the department is very excited by the commitment.

Dr. David Elliott Lewis asked for clarification on the meaning of health home.

Ms. Robinson explained that health home is just a terminology to indicate "local home" or location where people can get most medical services and mental health care. The significance of a health home is the convenience of accessing care in one place, rather than traveling to several different clinics for various types of care. It is especially important for people with mental illness who feel less stigmatized and discriminated by obtaining mental health care at their health home, or for people with a physical disability who will not have to travel far. An integrative care system means having a centralized record keeping of an individual's health history.

Mr. Moore wanted to know where health homes would be located in San Francisco

Ms. Robinson stated the roll out of health homes will be at the following locations: Mission, Sunset, Chinatown and South of Market, respectively.

1.2 Public Comment

Mr. Hove is an RN with CPMC and commented about his filming project titled the "Diseased Mind". The filming project is a documentary highlighting and educating the public about the implementation of the Affordable Healthcare Law in treating people with mental illness, addiction and medication/drug coverage. The documentary also shows the stigma and discrimination of people with mental illness who silently suffer in isolation and loneliness, sometimes leading to suicides.

Monthly Director's Report
November 2013

1. Diane Prentiss Presented at the American Evaluation Association Annual Conference

Diane Prentiss, Epidemiologist and Program Evaluator for the CBHS Office of Quality Management (OQM), delivered a presentation at the American Evaluation Association (AEA) annual conference in Washington DC in October. She spoke of the core skills required of an evaluator leading a quality improvement project in behavioral health. Under the guidance of the California Institute for Mental Health (CiMH), Diane coached a multidisciplinary team of staff from UCSF Citywide Forensics, South of Market Mental Health, OQM and MHSA through the "Advancing Recovery Practice Learning Collaborative" for 14 months. Training in and following the Institute for Healthcare Improvement Model for Improvement, the team conducted several Plan-Do-Study-Act (PDSA) tests designed to build client and clinician hope for recovery, identify clients ready to move on, and facilitate successful transitions to independent living with support from outpatient services if needed. Traditional evaluation skills that proved most valuable to the process included: skillful design of PDSA tests, development of useful data tools, identification of meaningful outcome indicators, assistance in interpreting findings and applying new knowledge to practice change. Unexpected skills that proved essential included: staying balanced in managing multiple PDSAs, remaining patient with slow progress, being clued in to the needs of the PDSA team, and keeping the team focused on the goal of improvement (i.e. client recovery).

(Attachment 1)

2. Access to Opioid Addiction Treatment in CBHS

Addiction to heroin and prescription opioids remains a public health concern. Fortunately, we have safe and effective options for our patients. One of the most accessible options is treatment with buprenorphine (commonly called Suboxone or Subutex) which is available in office settings such as primary care and behavioral health clinics. Buprenorphine can be prescribed by trained physicians and dispensed by community pharmacies similar to other maintenance medications.

Patients interested in treatment of opioid addiction should be referred to OBIC, which is the Outpatient Buprenorphine Induction Clinic. The clinic is located on the 2nd floor of 1380 Howard St. and can be reached by phone at 415-552-6242.

Patients who are just starting on buprenorphine at OBIC or who require more intensive monitoring can receive their medication from the CBHS Pharmacy located on the 1st floor of 1380 Howard St. CBHS pharmacists work closely with patients and prescribers to coordinate care, monitor for changes in psychiatric symptoms, assess substance use, and support adherence.

3. New CMHDA Resources on Steinberg's 5150 Legislation

CMHDA has posted two resources on their State Legislation website for members to learn more about Senate Pro Tempore Darrell Steinberg's bill, SB 364, which makes changes to the Lanterman-Petris-Short (LPS) Act regarding "5150" involuntary holds. The first item is a memo to CMHDA members with a simply worded overview of the key provisions of the bill. The other item is a "mock up" of current law showing specifically how SB 364 would change the LPS Act. As you may recall, CMHDA worked closely with Senator Steinberg's office and Disability Rights California on the bill

over the past year, which Governor Brown signed into law last month. The bill goes into effect on January 1, 2014. <mailto:kbarlow@cmhda.org>

4. Overview of New 2013 State Laws Now Available to CMHDA Members

CMHDA members can now read an overview of all the key bills signed into law that CMHDA closely tracked over the past year. Posted on CMHDA's State Legislation web site, our memo briefly describes new laws in the areas of mental health, health care, schools, criminal justice, and veterans that are of most interest to county mental health departments.

5. Statewide Suicide Prevention

Media Plan overview - The second flight of the Know the Signs campaign launched in mid-September and will run through January 2014. This campaign is geared toward direct helpers of those who may be at risk of suicide and directs these helpers to suicide prevention resources. Media strategies spanned cable and satellite television, magazines, online presence, bulletins, posters and cinema media in English and Spanish. For full details contact Stephanie Welch at Stephanie.welch@calmhhsa.org

My3 Suicide Mobile Phone App overview - The goal of the My3 Suicide Prevention mobile application is to connect individuals who are at risk for suicide or individuals who are feeling suicidal with their crisis support network. Mental health care providers or other caregivers can identify individuals who may be at risk for suicide, and endorse the FREE download and use of My3. The app can be downloaded at the App Store (for Apple phones) and Google Play (for Android phones). For full details contact Theresa Ly at tly@edc.org

Linea de Crisis - The San Francisco Suicide Prevention Partnership launched its new Spanish Language Crisis Hotline "Linea de Crisis" that provides Spanish language crisis support to the Bay Area. Hotline staff and volunteers are Spanish speaking, and the hotline is open from 1pm to 9pm everyday with expanded hours coming soon – (800) 303-7431. For full details contact David Paisley at (415) 984-1900, x106.

6. Roban San Miguel – Mission Family Center

We are pleased to announce two important hires for Children, Youth and Families. Roban San Miguel has accepted the position as Clinic Director for Mission Family Center. Mission Family Center is located in the heart of the Mission and focuses on serving children, youth and families that live in the district and/or the bicultural/bilingual Spanish speaking community. Roban has extensive experience as a clinician, clinical supervisor and clinic director most recently as director of the Special Programs for Youth at the Youth Guidance Center. She is a strong advocate for the community and community based services and brings a wealth of knowledge and experience to Mission Family Center. Roban will start her new position in February.

7. Coordinator for Trauma Informed Systems

The Department of Public Health has committed itself to developing its workforce to be trauma informed. This initiative referred to as the Trauma Informed Systems (TIS) is designed to increase overall understanding of the fundamentals of trauma. Consistent with a national movement, DPH will train all levels of the workforce and provide ongoing coaching and supervision to support a trauma sensitive system. The desired outcomes will include greater understanding of the impact of trauma on ourselves, our colleagues, our collaborators and ultimately the consumers. A small core group has been working on developing the Curriculum and we have vetted parts of the plan with over 400 people within and outside the system. We are hoping to begin training staff in February. Kaytie Speziale has been hired to coordinate this effort for DPH.

8. Obama Administration Issues Final Rule on Mental Health and Substance Use Disorder Parity

The Departments of Health and Human Services (HHS), Labor and the Treasury today (Friday, November 8, 2013) jointly issued a final rule increasing parity between mental health/substance use disorder benefits and medical/surgical benefits in group and individual health plans.

The final rule issued today implements the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008 (MHPAEA), and ensures that health plan features like co-pays, deductibles and visit limits are generally not more restrictive for mental health/substance abuse disorders benefits than they are for medical/surgical benefits.

Today's action also includes specific additional consumer protections, such as:

- Ensuring that parity applies to intermediate levels of care received in residential treatment or intensive outpatient settings;
- Clarifying the scope of the transparency required by health plans, including the disclosure rights of plan participants, to ensure compliance with the law;
- Clarifying that parity applies to all plan standards, including geographic limits, facility-type limits and network adequacy; and
- Eliminating the provision that allowed insurance companies to make an exception to parity requirements for certain benefits based on "clinically appropriate standards of care," which clinical experts advised was not necessary and which is confusing and open to potential abuse.

The Affordable Care Act builds on MHPAEA and requires coverage of mental health and substance use disorder services as one of ten essential health benefits categories. Under the Essential Health Benefits rule, individual and small group health plans are required to comply with these parity regulations beginning in 2014. Qualified Health Plans offered through the Health Insurance Marketplaces (e.g. Covered California) in every state must include coverage for mental health and substance use disorders as one of the ten categories of essential health benefits, and that coverage must comply with the federal parity requirements set forth in MHPAEA. The Department of Health and Human Services (HHS) has also released guidance explaining how federal parity requirements will be applied to the Children's Health Insurance Program (CHIP), Medicaid managed-care organizations, and Alternative Benefit Plans.

According to HHS, by issuing this rule, the administration has now completed or made significant progress on all 23 executive actions included in the President and Vice President's plan to reduce gun violence. In January, as part of the President and Vice President's plan to reduce gun violence, the Administration committed to finalize this rule as part of a larger effort to increase access to affordable mental health services and reduce the misinformation associated with mental illness.

The final Mental Health Parity and Addiction Equity Act rule was developed based on the department's review of more than 5,400 public comments on the interim final rules issued in 2010. CMHDA is in the process of reviewing the 206 page rule in its entirety and will be working with our coalition partners to better understand the implications for not only California's commercial health care market, but also our Medi-Cal program.

Past issues of the CBHS Monthly Director's Report are available at:

<http://www.sfdph.org/dph/comupg/oservices/mentalHlth/CBHS/CBHSdirRpts.asp>

To receive this Monthly Report via e-mail, please e-mail reanna.albert@sfdph.org

ITEM 2.0 MENTAL HEALTH SERVICE ACT UPDATES AND PUBLIC HEARINGS

The passage of Proposition 63 (now known as the Mental Health Services Act or MHSA) in November 2004, provides increased annual funding to support county mental health programs. The Act addresses a broad continuum of prevention, early intervention and service needs and the necessary infrastructure, technology and training elements that will effectively support this system. This Act imposes a 1% income tax on personal income in excess of \$1 million. One of the requirements of the Act is that the county must provide annual updates as well as hearings for changes in the way the county implements the funding.

2.1 Mental Health Services Act Updates: Mental Health Services Act Annual Update

Mr. Robinson stated that the annual Mental Health Awards Ceremony is a validation celebrating recovery and wellness. The October 2013 Mental Health Awards had 15 planners, over 200 award recipients and 500 attendees. Dr. David Elliott Lewis, Co-Chair of the Mental Health Board was one of the 15 planners, and he has been involved in the celebration for several years.

She announced that MHSA has a new program. It is called First Impression and the program's providers are helping clients to acquire vocational skills in high paying jobs like carpentry, painting and remodeling. MHSA is placing clients with Asian Designs and Citywide Services Clinic, so far.

She announced and encouraged the board and members of the public to attend the next MHSA Advisory meeting on December 18th, 2013 at 2 PM at 1380 Howard.

2.2 Public comment

No public comments.

ITEM 3.0 ACTION ITEMS

3.1 Public comment

No public comments.

3.2 PROPOSED RESOLUTION: Be it resolved that the notes for the Mental Health Board meeting of October 9, 2013 be approved as submitted.

Unanimously approved

ITEM 4.0 PRESENTATION: CRISIS SERVICES AFTER DARK ON THE STREETS OF SAN FRANCISCO: NIGHT MINISTRY, REV. LYLE J. BECKMAN; AND REV. DIANA WHEELER, DEACON ASSIGNED TO NIGHT MINISTRY LYLE BECKMAN AND DIANA WHEELER

4.1 Presentation: Crisis Services After Dark on the Streets of San Francisco: Night Ministry, Rev. Lyle J. Beckman; and Rev. Diana Wheeler, Deacon Assigned to Night Ministry.

Reverend Beckman is one of the night ministers. He provided a brief history of the San Francisco Night Ministry, which will celebrate its 50th anniversary, next year, in 2014.

Night Ministry began in the fall of 1964 to meet the need for counseling services in the middle-of-the-night during which many people, typically, experience the most intensive psychological crises, since social services and churches are closed after hours.

The post Summer of Love movement left many young, disillusioned people who came for the counter culture experiences and social experimentation with drugs stranded in San Francisco and unable to return to their families of origin. Night ministers reached out to many young people to offer compassionate, non-judgmental pastoral care and linkage to services.

Then, during the 1980's, San Francisco was the epic center of the AIDS crisis. Ignorance combined with socially sanctioned discrimination resulted in many victims of AIDS at the prime of their lives who were not only losing their homes and careers but also were being ostracized and shunned by their own birth families. During this time, holding funeral services in churches for AIDS victims were almost impossible due to the stigma and discrimination. Night ministers were comforting dying victims and conducting celebration of life services in bars and clubs.

Night ministers provide counseling, referral and crisis services to anyone in any kind of distress during the hours between 10 PM – 4 AM every day. There are ordained clergies working the streets of San Francisco to provide crisis intervention services to all persons regardless of age, gender, ethnicity, sexual orientation, life style, social or economic status, religion or no religion.

Night clergies walk the streets of San Francisco to engage people in serious conversations on issues like anxiety and depression, isolation, loneliness and grief and, and the most recent trend, aging and disability.

If the street is too uncomfortable for any one in distress, ministers will even meet people anywhere in San Francisco. For examples, ministers have met with people in coffee shops, private homes, bars, transportation centers, hotel lobbies, and hospitals.

Regardless of weather conditions, Night Ministry sponsors three Open Cathedrals in Civic Center, Mission and Castro for people living on the streets of San Francisco and/or people with mental health issues, since often these people feel too alienated in traditional worshiping environments. The open-air services not only provide non-traditional worshiping but also include meals afterward.

Open Cathedrals are located in Civic Center (Leavenworth and McAllister on Sundays at 2 PM followed by lunch); Mission (16th Mission BART station on Thursdays at 5:30 PM followed by dinner) and Castro (Castro Virtual Community).

Tuesday night gatherings are called a Bible class. It is mainly a get-together to talk. Night Ministry conducts an annual average of 11,000 – 13,000 middle-of-the-night conversations and serves 10,000 meals.

Reverence Deacon Wheeler said she started with Night Ministry in 2008. From 10 PM – 2 AM is Crisis Line Counseling via a telephone and from 2 AM to 4 AM is face-to-face conversations.

She added that callers are lonely and often stay awake at night struggling with anxiety and depression and, recently, with aging and disability. There are people who call Night Ministry every night. For example, one person has called just about every night for 34 years. Ministers have a long-term relationship with callers and people on the street.

Reverend Beckman said night ministers collaborate with San Francisco Suicide Prevention for referrals.

Ms. Bohrer wondered about funding.

Reverend Beckman said the funding allocations are 45% from individuals, 15% from annual fall benefits (Fall Gala), 15% from matching grants and foundations, 15% from community fundraising, and 10% from the congregation.

Reverence Deacon Wheeler added that community fundraising comes from local non-profit organizations like Sisters of Perpetual Indulgence and San Francisco Imperial Court who donate their fund raising proceeds to Night Ministry.

Dr. Patterson said years ago he went out on a night ministry walk with Reverend Don Steyart and wondered how situations on San Francisco streets have changed over the years.

Reverend Beckman said in the early years during the late 1960's, lots of lost young people were desperately in trouble with substance abuse and sex work. Suicide Prevention was the only 24 hour hot line. Ministers were initially focused on linkages to services for these youth.

Then, during the 1980's there was the AIDS epidemic. Reverend Chuck Lewis worked with the AIDS community to reduce the fear of HIV and AIDS. He sat and comforted many dying victims and conducted funeral services in bars and clubs. When ordained clergies were performing diagnostic blood tests for HIV, San Francisco made national and international news.

Now, Night Ministry is focusing on people with mental illness who are being taken advantage of and being victimized by violence, because they are so awake at night that they are wandering on the streets.

Mr. Vinh commented that he is a contractor for San Francisco Suicide Prevention and wondered how much time is allocated for face-to-face meeting.

Reverend Beckman said normally it is 10 minutes to stabilize a person, but exceptions are made in very serious circumstances.

For a Crisis Line Counselor telephone talk, there is no time limit. An average talk can last 20 minutes to an hour.

Night Ministry also connects with Women Inc. to take battered or abused women to the hospital.

Ms. Bohrer asked about the average number of engagements.

Reverend Beckman said there are three full-time ministers of 14 ministers who each average around 2-4 engagements per night.

With women in crisis situations, a woman minister will come along with a male minister.

Ms. Virginia Lewis said she served on the board of Night Ministry for five years, and is still very touched by Open Cathedral.

Reverend Beckman said Open Cathedral has been going on for years and has transformed into a community where people help each other through difficult times.

Reverence Deacon Wheeler said Open Cathedrals started in the Civic Center, expanded to Mission and Castro, and now to Bayview/Visitation Valley.

Ms. Bohrer asked what additional mental health services are needed that are not available in the middle-of-the-night.

Reverend Beckman said Night Ministry is in the process of developing a full-time wellness program to include mental health professionals on nightly walks along with ministers to do crisis

intervention for people in the middle of an acute crisis and help people in distress articulate themselves better.

Ms. Robinson asked if Night Ministry has any relationship with DORE Urgent Care Clinic.

Reverend Beckman said Night Ministry has often taken clients/patients to DORE.

Dr. David Elliott Lewis asked about non-faith callers with crisis in need of a non-faith response, since only 30% of night calls are religiously connected.

Reverend Beckman said Night Ministry is an inter-faith and ecumenical 501c3 organization, meaning it is not connected to a specific faith.

Reverence Deacon Wheeler said most of the conversions with callers are non-faith based responses.

Mr. Vinh personally believed that ministers wearing a religious collar during night walks is a necessity for ease of identification and to create an immediate trust.

Reverend Beckman said he had received calls from Muslims who want anonymity and prefer non-faith based responses, rather than going to a Mosque to discuss their psychological issues with an imam or khalifah.

Dr. Patterson wondered how the Mental Health Board can support Night Ministry.

Reverend Beckman said he would like board members to join in an Open Cathedral.

Ms. Virginia Lewis suggested board members can participate in annual benefits for the Night Ministry.

Ms. Chien commended the work of Night Ministry and its commitment to have mental health professionals to train the 14 ministers.

Reverend Beckman said having a mental health professional comes along with a night minister will be very helpful.

He shared that about 70% of the callers they have talked with are isolated seniors, with most of them being women. Aging well is a big concern for many callers.

Ms. Robinson wondered if Night Ministry receives any CBHS training notices.

Ms. Virginia Lewis pointed out that one of the night ministers is a bi-lingual Spanish-English speaker, and commented that there is a huge stigma and discrimination against mental illness in the Latin and Hispanic cultures.

4.3 Public Comment

Ms. Nigusse from Westside Crisis Clinic shared that she is appreciative of Night Ministry and wanted to know more about its other language capability.

Reverend Beckman said Night Ministry has English, German, Japanese, Korean speakers, and there are stand-by Chinese speaking staff as well.

Mr. Hickman works with age 55+ population at Family Services Agency (FSA). He shared that FSA clients have shared that the middle-of-the-night calls to Night Ministry have gotten them through many crisis nights. He would like to be a volunteer with Night Ministry.

ITEM 5.0 REPORTS

For discussion

5.1 Report from the Executive Director of the Mental Health Board.

Ms. Brooke made the following announcements

- November 15th, 2013 Peer Respite event hosted by MHA-SF.
- December 13, 2013 is the 6th Annual Family and Consumer Conference with Laura Brainin-Rodriguez, MPH, MS, RD.; Eve Myers, ED of San Francisco Suicide Prevention; and a panel of four clients, who will share "Living the Wellness and Recovery Model." Family and Consumer support are critical to the journey of wellness and recovery from mental illness, and they will provide useful tools to assist people through the 2013 holiday season.

5.2 Report from the Chair of the Mental Health Board and the Executive Committee.

Mr. Joseph reminded the board that the 2013 working retreat is scheduled for Saturday December 7th from 10 – 4 at the San Francisco Police Academy in Diamond Heights at 350 Amber Street in San Francisco. Jo Robinson will give a report in the morning and then Roma Guy, former President of the Health Commission, will give a presentation on strengthening our advocacy skills.

And if others would like to participate in the final planning of the retreat, they should feel free to come to the next Executive Committee meeting on Thursday, November 21st at 1380 Howard Street, Room 515 at 6:30 PM.

He also talked about suicide rates in the U.S. Armed Forces which is higher than the total number of troops killed in action since the war started in 2003. He would like board member to keep awareness about veteran suicides.

Dr. David Elliott Lewis mentioned Dr. Patrick Corrigan who is an author and an advocate against the stigma of mental illness. He has written more than ten books and more than 300 papers specializing in issues related to mental illness. One of his most noted books is "Don't Call Me Nuts: Coping with the Stigma of Mental Illness", which discusses many issues relating to mental illness including the issue of indiscriminate disclosure.

Dr. Lewis is a strong advocate for reducing stigma and would like to do public service education via TV to educate the public about the silent sufferings of people living with mental illness. He wants to personalize it by having the public seeing people with mental illness as people rather than seeing them as a diagnosis.

5.3 People or Issues Highlighted by MHB: Recognition of people and/or programs that the board believes should be acknowledged and highlighted or issues of concern to the Mental Health Board that the board wishes to bring attention to.

Dr. David Elliott Lewis wanted to recognize the outstanding work of San Francisco Night Ministry.

Ms. Bohrer wanted to recognize Ms. Terri Byrne from MHA-SF for her "Send a Card" campaign to hospitalized patients/clients with mental illness.

5.4 Report by members of the Board on their activities on behalf of the Board.

Dr. David Elliott Lewis met with Supervisor Jane Kim and Ed Riskin of SF MTA to discuss pedestrian deaths and safety on 6th and Market streets.

Ms. Virginia Lewis met with Supervisor Mark Farrell to discuss the Laura's Law in San Francisco.

5.5 New business - Suggestions for future agenda items to be referred to the Executive Committee.

Dr. Patterson wanted a VA representative to talk about the network of services in the VA system.

Dr. David Elliott Lewis wanted to submit the SF AIMS project on Golden Gate. The project focuses on nutritional education around metabolic disorders.

Ms. Miller would like to explore the topic of medication effects on sleep.

5.6 Public comment.

No public comments.

ITEM 6.0 PUBLIC COMMENT

Public member stated that there is so much stigma, discrimination and ignorance surrounding mental illness that the general public does not understand. He felt the MHSA awards ceremony will help people better understand compassionately the challenges that individuals with mental illness face in the recovery journey.

ADJOURNMENT

Meeting adjourned at 7:53 PM.



SAN FRANCISCO MENTAL HEALTH BOARD



Mayor
Edwin Lee

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Mental Health Board Annual Retreat

Saturday, December 7, 2013
San Francisco Police Academy
350 Amber Drive, S.F., CA
10:00 a.m. – 4:00 p.m.

AGENDA

- 1.0 Getting to Know You Icebreaker
 - 1.1 Public Comment
- 2.0 Mental Health Director's Report
 - 2.1 Public Comment
- 3.0 Strategies for Increasing Mental Health Advocacy: Roma Guy
 - 3.1 Public Comment
- 4.0 Discussion about the following topics:
 - What would you like to see as training for incoming board members?
 - Review of how we have been doing – have each board member evaluate: What have you liked the most about being on the board and what have we done that you particularly liked? What has been most interesting and valuable to you the past year?
 - If you have done program reviews, what is the most and least valuable part of the visits to programs?
 - What are your greatest passions regarding mental health?
 - What inspires you the most within mental health and your own domain?
 - What resolutions would you suggest that the board do in the coming year?
 - 4.1 Public Comment
- 5.0 New Directions for 2014

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Discussion

- Advocacy
- Program Reviews
- Outreach, Website
- Topics/Speakers
- Public Forums

5.1 Public Comment

Adjourn

No votes will be taken on any items at the Retreat. All issues arising at the Retreat which require a vote of the Board will be placed on the agenda for the regular meeting of the Board on January 8, 2014. For further information, please call the office at 415-255-3474.

DISABILITY ACCESS

1. San Francisco Police Academy is accessible to persons using wheelchairs and others with disabilities. Free parking in the parking lot is available. Assistive listening devices, materials in other alternative formats, American Sign Language interpreters and other accommodations will be made available upon request. Please contact Darlene Daevu, Community Behavioral Health Services, 415-255-3426 or by email:

Darlene.daevu@sfdph.org. Providing at least 72 hours notice will help to ensure availability. To reach a TTY line, call (415) 255-3449. Large print copies of the agenda will be made available upon request; please call (415) 255-3474.

2. The closest accessible BART station is the Glen Park station, at the intersection of Bosworth and Diamond Streets. The 48 Quintara and 52 Excelsior lines stop within two blocks of Amber Drive. For more information or updates about the current status of MUNI accessible services, call (415) 923-6142. For information about Paratransit Services call (415) 351-7000.

3. The San Francisco Police Academy is accessible to wheelchairs. Elevators, doorways, restrooms, and the meeting room is wheelchair accessible.

4. In order to assist the City's efforts to accommodate persons with severe allergies, environmental illnesses, multiple chemical sensitivity or related disabilities, attendees at public meetings are reminded that other attendees may be sensitive to various chemical based products. Please help the City accommodate these individuals.

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Sunshine Ordinance Task Force
City Hall, Room 244
1 Dr. Carlton B. Goodlett Place
San Francisco, CA 94102-4689
Telephone: (415)554-7724
Fax: 4(15) 554-5163
E-mail: sotf@sfgov.org

Citizens interested in obtaining a free copy of the Sunshine Ordinance can request one from the Sunshine Ordinance Task Force or by printing Chapter 67 of the San Francisco Administrative Code from the internet at: www.sfgov.org/sunshine

To view Mental Health Board agendas and minutes, you may visit the MHB web page at: www.sfgov.org/mental_health. You may also go to the Government Information Center at the Main Library at Larkin and Grove in the Civic Center. You may also get copies of these documents through the MHB office at 255-3474.

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SAN FRANCISCO MENTAL HEALTH BOARD



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Unadopted Notes

Mental Health Board Retreat
Saturday, December 7, 2013
San Francisco Police Academy
350 Amber Drive
San Francisco, CA
9:30 a.m. – 4:00 p.m.

JAN - 6 2014

BOARD MEMBERS PRESENT: David Elliott Lewis, Ph D, Co Chair; Ellis Joseph, MBA, Co Chair; Wendy James, Vice Chair; Terry Bohrer, RN, MSW, CLNC; Virginia S. Lewis, MA, LCSW, Secretary; Sgt. Kelly Kruger; Kara Chien, JD; Terence Patterson, EdD, ABPP; and Alphonse Vinh, MS.

BOARD MEMBERS ON LEAVE: Melody Daniel, MFT; Lena Miller, MSW; Andre Moore; and Errol Wishom.

BOARD MEMBERS ABSENT: none.

OTHERS PRESENT: Helynna Brooke (MHB Executive Director); Loy M. Proffitt (Administrative Manager); Jo Robinson, Director of Community Behavioral Health Services (CBHS); Roma Guy; and Lara Minda Argüelles, former board member.

CALL TO ORDER

Mr. Joseph called the meeting of the Mental Health Board to order at 10:15 AM.

ROLL CALL

Ms. Brooke called the roll.

ITEM 1.0 GETTING TO KNOW YOU ICEBREAKER: TERENCE PATTERSON

Dr. Patterson led an ice breaker exercise for board members to share their thoughts about mental health services in San Francisco. Following were some of the responses by board members:

1. Have more mental health services available to every person in acute psychiatric crisis at Dore & Psychiatric Emergency Services (PES) of the San Francisco General Hospital.
2. Have the City established a self-referred 24x7 drop-in mental health care center
3. Have gender specific services for mental health and substance abuse.

4. Have public education to end stigma and marginalization of people with mental illness.
5. Have more mental health peers and consumers actively participate in all levels of respite care
6. Have the City make housing an urgent priority for people with mental illness who are homeless
7. Have court orders to take rights away from people who do not know their life could change for the better by conservatorship
8. Have program reviews and evaluations to quantify and to qualify any evidence based practices
9. Have mental health allies proactively monitor any mental health program shutdown
10. Have more comprehensive services for people with SMI (serious mental illness)

1.1 Public Comment

Ms. Arguelles agreed that program reviews should include funding disclosures.

ITEM 2.0 MENTAL HEALTH DIRECTOR'S REPORT

Ms. Robinson said new revenue streams in 2014 will come from serving more San Franciscans under the Affordable Care Act (ACA). Under the ACA, San Francisco Health Network is the new name. The network of care is team based care (TBC), and substance abuse disorder clinicians can conduct individual and group therapy sessions.

CBHS is consulting with Health Maintenance Associates (HMA) to help determine the future of mental health services in San Francisco. There is an opportunity to create a new system to benefit more people by integrating primary health care with mental health services and substance abuse programs. We will need to be very efficient and effective.

It is known that approximately 10%-11% of our clients don't engage with primary care because of personal challenges with their mental illness. There are several reasons for this. Some patients with mental health disorders feel clinicians speak tangentially and do not empathize with their lived experiences. Or, patients find it is too intimidating to sit in a primary clinic. Or many patients feel it is off-putting when their clinicians identify them by their mental health diagnosis rather than see them as a person with mental illness.

Health home funding for a Care Coordinator will be approved in January. Nurse practitioners will work with licensed social workers. We are currently doing trainings with primary care staff to train about mental health. Ryan Shackelforth, an Internist and Psychiatrist will help lead this process. All clinics will convert to Team Based Care (TBC), with multi-disciplinary clinicians and social workers to tend to a person's care. Every clinic will have substance abuse clinicians for assessment, treatment, and group therapy. We currently have four clinicians.

There will be a profound change for some clients. For example, a primary care clinician with mental health and substance abuse training will be serving more people with fewer dollars. A psychiatrist can provide supervision in peer run psychiatric respite.

Behavioral healthcare can be obtained at health homes. Two weeks ago, the state legislators started the approval process for health homes. Once the final approval is completed in January 2014, we must be ready to go live, because that is the time when the funding support begins for San Francisco.

The role out process of health homes starts in the locations of Mission, Chinatown, Sunset and South of Market clinics. These clinics provide multi-care services from primary care to behavioral health services. It is usually rare to have a dually board certified clinician with psychiatry and health care expertise which we are fortunate to have. Nurse practitioners will work with licensed social workers in coordinating care. Outcomes should be better this way.

One of the changes in health homes is that staff must follow up with no-show clients. We want clients to engage in their treatment and be more involved in community. Mental health parity means no more restriction on the number of visits for mental health or substance abuse related care.

Psychiatric respite used to be having one psychiatric medical director for psychiatry and having another medical director for medical. Now, with tight funding it means only one psychiatric medical director is needed to be in charge of both medical and psychiatry.

We have the following members leading the ACA implementation at CBHS: Deborah Sherwood, PhD, for mental health, Lisa Golden for substance abuse and Albert Yu for ambulatory care, respectively.

Dr. David Elliott Lewis asked for clarification on health homes.

Ms. Robinson explained that health home is San Francisco's version of maximizing health outcomes of the patient-centered medical home (PCMH). Having a team based health care delivery model allows patients to have better access to health care and support. Locations for health homes are in the Mission, Sunset, Chinatown and South of Market clinics.

2.1 Public Comment

Ms. Arguelles commented that non-compliant people with mental illness was not addressed in the ACA. She believed program reviews should have more affect.

ITEM 3.0 STRATEGIES FOR INCREASING MENTAL HEALTH ADVOCACY: ROMA GUY

Ms. Guy facilitated the session, and the following thoughts were shared. Ms. Guy has a system orientation background. She suggested board members identify for themselves what mental health means, such as being able to navigate basic needs, able to enjoy alone time, able to enjoy community, and think about what mental health board membership means to each of us.

Have stable relationships

Reality contact and consensually supported.

Have mental wellness

Have efficiency and wholeness in the delivery of mental health and substance abuse services

Have access to community programs quickly to prevent further health deterioration

Have more influence with board of supervisors and mayor, and health commissioners

There might be a collective mandate of the board but each member brings their own experiences to the board. Members need to be able to reflect on individual beliefs to affect community. Honesty and transparency are important too.

She said that the US is going through a profound change in healthcare. For the first time in 200 years of the US history, the US not only will have an integrated mental health and primary care but also will have mental health parity under the ACA.

The change in the ACA is an opportunity for the Mental Health Board to strengthen alliances with other community leaders and to make selective decisions on a county-wide basis, since the board cannot do everything.

Board members should think in terms of CSP (Cultural Structures Project). In culture, the board should find allies and people to collaborate with and should take into consideration people's beliefs in the system and their assumptions. In structure, the board should be influential in resource allocation. Structure determines resources and who gets them. Each board member could become a passionate advocate and develop their own "job" description.

She said that struggling and fighting is over values in the end. Board members should define and frame and take into policy implementation. Our goals and objectives are based on our beliefs both individually and collectively.

Since our society has an aversion toward evaluation, she encouraged board members to perform evaluations during program reviews and not just report back on what is going on in the community. The board should rhetorically ask "How do we want to position ourselves today?" Board members should proactively and continually refine their strategies.

People with mental illness have struggles and needs and they need someone to advocate for them, and the board could be an agent of change. Unfortunately, earlier decisions were made years ago to separate mental health and physical health. And we saw what happened during the 1960's when patients with mental illness were depopulated out of mental health hospitals back into the community that had no infrastructural capacity to care for them during the early years. Another phenomenon in San Francisco was a cultural belief about family housing. San Francisco was not family centered because the city was originally settled by a dominant culture of single white persons. The closure of mental health hospitals meant no family around to take in the discharged patients.

In a research study of San Francisco General Hospital, it was learned that even one-time incarcerated women have higher risks of mental health disorders and homelessness. For men, according to the research, income is a risk factor for homelessness.

3.1 Public Comment

Ms. Arguelles commented that the recent deaths on November 19, 2013 of West Virginia Senator Creigh Deeds and his son who had untreated mental illness were preventable.

Sgt. Kruger reported that UCSF is doing a project for people with SMI (serious mental illness).

ITEM 4.0 DISCUSSION ABOUT THE FOLLOWING TOPICS:

1. What would you like to see as training for incoming board members?

Pre-requisites for MHB candidate should include at least attending two board meetings; An incoming member should have a pre-orientation soon after appointment and have a board buddy to provide answers to questions.

2. Review of how we have been doing – have each board member evaluate: What have you liked the most about being on the board and what have we done that you particularly liked? What has been most interesting and valuable to you the past year?

Dr. Patterson along with Ms. Lewis would like a multi month thematic focus on a couple of broad issues at board meetings. He would like to have a deliberative and investigative board rather than just an informational board.

Ms. Lewis would like to revise the Director's Report to include follow ups on problematic issues in CBHS that come up during board monthly meetings.

Ms. Bohrer would like to share a different approach to advocacy than Roma Guy. She believed the name behavioral health board is an umbrella term for mental health board and substance abuse board.

Dr. Lewis wants psycho-education awareness on how unresolved traumas inflict mental illness and or substance abuse.

Ms. Chien appreciates board members presence at community celebratory events, for example the Behavioral Health Court's 10th Anniversary.

Alphonse wants to address the issue of underserved seniors with hidden mental illness that are not being addressed.

3. If you have done program reviews, what is the most and least valuable part of the visits to programs?

Ms. Chien and Ms. Lewis would like investigative journalists to come to a board meeting to address deficits and strengths of programs and services.

Increase the number of site visits.

4.1 Public Comment

Ms. Argüelles commented that she would like to see the Mental Health Board invite supervisors to board meeting. She suggested board members make their presence known at the Health Commission, Board of Supervisors, and Sheriff meetings.

Dr. Lewis suggested that the upcoming elections in 2014 is a good opportunity to approach supervisors about mental health issues who stand for re-election.

Ms. Brooke asked board members to individually and as a group to lobby a supervisor be on the Mental Health Board.

ITEM 5.0 NEW DIRECTIONS FOR 2014

Board members would like to have sub-committees to focus on needs and problems of various communities in San Francisco then report their findings back to the general board, so the whole board can take action. The board came up with the following “themes.”

1. CBO's are unable to renew their leases because they are priced out of the market, and there is a big concern that community programs may become inaccessible.
2. Seniors are vulnerable to isolation and loneliness and their senior mental health disorders are not being addressed adequately.
3. There are insufficient inpatient emergency psychiatric beds at SFGH
4. There is a lack of mental health treatment by local emergency rooms.
5. The board should submit editorials to the media
6. San Francisco needs to have after-hours mental health crisis response.
7. Mental health services in jails are inadequate due to an increase in criminalization of people with mental illness.
8. There is a revolving door of acute patients with mental illness due to premature discharge and improper follow up care.
9. Board members need to educate themselves on the Lanterman Petris Short Act (LPS) policies and issues.
10. The budget inequities perpetuate a dual system of public vs. private care.
11. There is a strong correlation between trauma and violence and mental health and substance abuse.
12. Inaccurate mental illness diagnosis can manifest into devastating impact.

13. There is a 6.5 year gap delay between mental illness symptoms and receiving proper treatment.
14. The board would like to see presentations from Ron Patton on conservatorship and Joan Cairns on jail psychiatric care.

5.1 Public Comment

Ms. Argüelles was glad to attend the retreat and to learn about the board future goals.

ADJOURNMENT

Meeting adjourned at 4:00 PM.

